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SOCIAL SECURITY

Refer to:
S9H: AM3735

October 9, 2015

I am responding to your June 15, 2014 Freedom of Information Act (FOIA) request. We apologize for the delay in our response and any inconvenience this may have caused you. You requested a copy of each response to a Question for the Record provided to Congress by the Social Security Administration.

I have reviewed your request under the FOIA (5 U.S.C. § 552) and located 584 pages that are responsive to your request. However, I have deleted portions of pages, withheld pages, and enclosures, pursuant to FOIA Exemption 3 and 6 as explained below.

We withheld federal tax information covered under the Internal Revenue Code (26 U.S.C. § 6103). Section 6103 of the Internal Revenue Code prohibits disclosure information under the circumstances of your request. The Freedom of Information Act (5 U.S.C. § 552(b)(3)) does not require disclosure when another law requires confidentiality.

In addition, we withheld some personal information that we provided to Congress pursuant to (5 U.S.C. § 552a(b)(9)) of the Privacy Act which allows release "to either House of Congress, or, to the extent of matter within its jurisdiction, any committee or subcommittee thereof, any joint committee of Congress or subcommittee of any such joint committee." However, FOIA Exemption 6 (5 U.S.C. § 552(b)(6)) exempts disclosing personal information that would be a clearly unwarranted invasion of personal privacy. When we receive a request from a member of the public to release personal information about another individual from our records, we must balance the individual's privacy interest in withholding the information against the public interest in disclosing the information. We must determine whether disclosure would affect a personal privacy interest. Individuals clearly have a substantial personal privacy interest in the personal details furnished to the Government. On the other hand, the only public interest we must consider is whether the information sought would shed light on the way an agency performs its statutory duties. We may not consider the identity of the requester or the purpose for which the information is requested. While the public has an interest in knowing how the Social Security Administration administers the Social Security Act, disclosing records containing personal information about named individuals would not shed light on how the agency performs its statutory duties. Therefore, disclosing the personally identifiable information of

this information would be a clearly unwarranted invasion of personal privacy, and the FOIA does not require disclosure.

If you disagree with this decision, you may appeal it. Mail the appeal within 30 days after you receive this letter to the Executive Director for the Office of Privacy and Disclosure, Social Security Administration, 617 Altmeyer Building, 6401 Security Boulevard, Baltimore, Maryland 21235. Mark the envelope "Freedom of Information Appeal."

Sincerely,

Keisha Mahoney-Jones

Keisha Mahoney-Jones
Acting Freedom of Information Officer

Enclosure

SOCIAL SECURITY

The Commissioner

May 29, 2009

The Honorable Sam Johnson
Ranking Member, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Johnson:

Thank you for your April 9, 2009, letter requesting additional information to complete the record for the "Joint Hearing on Eliminating the Social Security Disability Backlog," held on March 24, 2009. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Angela Arnett, our Acting Deputy Commissioner for Legislative and Regulatory Affairs, at (202) 358-6030.

Sincerely,

/s/

Michael J. Astrue

Enclosure

SOCIAL SECURITY

The Commissioner

May 29, 2009

The Honorable John Linder
Ranking Member, Subcommittee on Income
Security and Family Support
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Linder:

Thank you for your April 9, 2009, letter requesting additional information to complete the record for the "Joint Hearing on Eliminating the Social Security Disability Backlog," held on March 24, 2009. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Angela Arnett, our Acting Deputy Commissioner for Legislative and Regulatory Affairs, at (202) 358-6030.

Sincerely,

/s/

Michael J. Astrue

Enclosure

Questions for the Record Subsequent to the March 24, 2009 Hearing
Before the House Committee on Ways and Means
Subcommittees on Social Security and Income Security and Family Support

1. **The President's Fiscal Year 2010 budget (p.18) says the Administration would like to "work with Congress to revisit asset limits for Federal means-tested programs." In the last Congress, senior Democrat Representative John Conyers introduced a bill (H.R. 3172) that would repeal asset limits for the Supplemental Security Income (SSI) program under the Ways and Means Committee's jurisdiction. Under the Conyers bill, any disabled person who currently has a low income would be eligible for SSI, regardless of how much he or she has saved in the bank or in stocks, regardless of how big a house he or she might own, and regardless of how much his or her car costs.**

   Does the Social Security Administration (SSA) support the policy in the Conyers bill? If not, what asset limit reform policy does the Obama Administration support, specifically with regard to the SSI program? Also, how many more SSI recipients would there be if asset limits were eliminated? How much would that cost?

   We fully support the Administration's proposal to revisit asset limits for Federal means-tested programs. While we have not yet taken a position with regard to the specific provisions in H.R. 3172, we note that during the last 20 years, the SSI resource limit has not been raised and there have been no significant changes in the types or amounts of resources excluded from consideration.

   Because we have limited data on the number of persons who might become eligible for SSI benefits if the asset test were completely eliminated, we would need to develop better data to fully explore revising these asset limits.

2. **A January 8, 2009 Office of Management and Budget (OMB) report entitled "Improving the Accuracy and Integrity of Federal Payments" indicates that 12 programs accounted for approximately 90 percent of reported improper payments for a total of an estimated $65 billion in fiscal year 2008. Included in this "top 12" list is the Social Security Administration's (SSA's) SSI program with estimated fiscal year 2008 improper payments of $4.5 billion -- a rate of over 10 percent. This 10 percent improper payment rate is up substantially from the fiscal year 2004 rate of 7.4 percent. What are the main causes of these improper payments, and what is the SSA doing to reduce the number of improper payments? What can Congress do to help with this effort?**

   The amount and number of incorrect payments have grown primarily because we have had to reduce the number of redeterminations due to a lack of resources. As discussed in my testimony, we are now beginning to increase the volume of redeterminations. In FY 2009, we will perform 1,711,000 redeterminations, an increase of 490,000 over the FY 2008 level. As part of a government-wide effort to reduce improper payments, the FY 2010 President's Budget includes a significant increase in our funding for program integrity activities, including redeterminations. In FY 2010, we plan to process 2,322,000 redeterminations, which would be over 600,000 more redeterminations than we expect to complete in FY 2009.

In FY 2008, the two major reasons for improper payments in the SSI program were recipients' failure to fully report wages that they earned or funds that they held in financial accounts. Between FY 2004 and FY 2007, these types of improper payments grew to $400 million and $500 million, respectively.

To address these major causes of payment error, we have a number of initiatives underway that will permit us to obtain information we need to pay beneficiaries correctly. One such initiative is the Telephone Wage Reporting project, which permits working SSI recipients to easily report wages. We are gradually increasing the number of participants in the program. Another initiative is the Access to Financial Institutions project in which we access account information directly from the financial community. This project is currently operating in three States: California, New Jersey, and New York. The FY 2010 President's Budget includes language which would allow us to expand asset verification initiatives such as the Access to Financial Institutions project, if these projects are found to be as cost-effective as redeterminations.

3. **The President's budget request included an adjustment in the overall allocation for annual appropriations for program integrity reviews; but experience tells us that these allocations aren't ironclad, particularly when funding is provided through a continuing resolution or if some funds are later rescinded. Have you talked to OMB and the appropriators about some type of no-year capital budget to fund program integrity efforts or needed technology investments?**

Our FY 2009 appropriation allows us to begin to reverse the overall decline in program integrity reviews. The FY 2010 President's Budget provides us with $758 million to further increase our program integrity efforts. These efforts will further ensure that the Government spends tax dollars efficiently and that we correctly pay benefits only to those persons who are eligible.

In FY 2009, we plan to process 1,079,000 periodic CDRs, including 329,000 medical CDRs. The President's budget allows us to maintain the higher level of medical CDRs in FY 2010. We also plan to process 2,322,000 SSI redeterminations. Even with this increase, we will still perform fewer program integrity reviews than we did earlier in this decade.

We have had tight budgets in the recent past, and when resources are limited, we must balance our program integrity efforts against maintaining service to the public. Sustained, adequate, and timely funding is vital to ensuring our ability to meet both our important service and stewardship commitments. The additional funding provided by Congress in FY 2009 is helping us make a positive difference in all of the work we do.

Regarding a no-year capital budget to fund needed technology investments, we have considered this and are extremely grateful for the additional $500 million in no-year funding for a new National Computer Center. We look forward to discussing with you how the President's Budget will help us with other necessary investments to modernize our information technology infrastructure and provide 21st century customer service to the public.

4. **Please explain how average hearing processing time is defined. Why is there so much fluctuation in the hearing offices' numbers?**

We define average processing time (APT) as the average number of calendar days from the hearing request date to the disposition date for all dispositions during a reporting period. Differences in data can occur because we may be calculating APT for different reporting periods. For example, the APT for a certain month usually would be different than the APT for FY to date, i.e., calculating APT for all dispositions from the beginning of the fiscal year to the date the APT is calculated. The best barometer for APT is the fiscal-year-to-date calculation. In addition, the APT varies from hearing office to hearing office because some offices have more aged cases than other offices. Thus, offices with high numbers of aged cases due to large backlogs and offices that assist other offices in processing their aged case workload tend to have higher APTs.

Due to the many obstacles to expansion of the hearing offices, the location and size of the hearing offices is essentially the same as it was twenty years ago, even though the demographics of the claimant population have changed dramatically. We have undertaken with our recent expansion to take changed demographics into account, which is why the expansions are focused in the Rust Belt and Southwest.

5. **Last year, for the first time, your Chief Administrative Law Judge (ALJ) set a production expectation for the Agency's 1000+ judges. He asked each judge to process between 500 and 700 cases during the year. On average, how many cases is that per day? How did your Chief Judge arrive at this number? What are you doing about those that failed to achieve the goal?**

The Chief Administrative Law Judge (ALJ) requested all ALJs to process 500–700 dispositions each fiscal year. Since there are approximately 250 work days in the fiscal year, each ALJ would need to decide, on average, between 2 to 2.8 cases per work day. We used personal experience and historical data to set the goals. The Office of the Inspector General (OIG) performed an independent review in February 2008 and agreed that this ALJ productivity level was reasonable. Combined with other backlog initiatives, we will eliminate the hearing backlog by 2013 if the ALJs meet these goals.

We currently use benchmarks and timeliness measures to address ALJ performance issues. We have established benchmarks for processing cases through all major steps, from receipt of the hearing request to a decision. We counsel ALJs whose case processing takes longer than the benchmarks. In addition, we have formed a cross-component workgroup to review issues related to ALJ performance, including identifying the steps we can legally take to establish an acceptable productivity level. Until we complete this review, we will continue to address issues related to ALJ productivity based upon timeliness.

6. **Data provided to Representative Tiberi regarding the Office of Disability Adjudication and Review in Columbus, OH suggests the number of pending disability cases has increased from FY08 to FY09. Pending cases have increased from 8,461 in FY08 to 9,640 in FY09 and the average number of cases per ALJ has increased from 826 in FY08 to 945 in FY09.**

The current average annual ALJ production expectation of between 500-700 cases is significantly lower than the average number of cases pending per judge in the Columbus office. When will the number of pending cases in the Columbus office decrease? What resources are being used to help this office operate more efficiently, and are there any plans to add more Administrative Law Judges (ALJs) and/or other staff to increase case processing capacity?

Representative Tiberi accurately cited the data for the Columbus hearing office. The office ended FY 2008 with 8,461 cases pending, and at the end of February 2009, there were 9,640 cases pending. Also, at the end of February, there were 944.60 pending cases per ALJ, reflecting an increase over the 826.10 pending cases per ALJ at the end of FY 2008.

The Columbus hearing office began receiving assistance from the Springfield, MA hearing office in 2008 as part of our Service Area Realignment initiative. The Springfield hearing office is responsible for hearing cases from the Mansfield, OH, and Wooster, OH, service areas, which were previously heard by the Columbus hearing office. This fiscal year, the Columbus hearing office has also received assistance from the San Francisco Screening Unit.

In addition, we plan to establish a new hearing office in Toledo, OH, in FY 2010, which will service areas currently handled by the Columbus hearing office. We will closely monitor the Columbus hearing office's situation and if necessary, may transfer additional cases out of the Columbus hearing office or realign the Columbus hearing office's service area.

In FY 2008, we placed two additional ALJs in the Columbus hearing office, bringing the total number of ALJs to 10. The office has physical capacity for only 10 ALJs, so we cannot place any additional ALJs in that office this fiscal year. However, the hearing office plans to fill one additional support staff position this fiscal year.

ALJ productivity in Columbus is currently near the lowest in the country and we are hopeful that additional resources and counseling will improve their productivity.

7. **In your written testimony, you said that you might need 1,400-1,450 ALJs to handle the increasing hearings backlog. What can the Office of Personnel Management (OPM) do to help you hire ALJs?**

The Commissioner recently spoke at length with OPM Director Berry about the short-term problem in hiring ALJs and our long-term issues, and asked that the register of ALJs be refreshed as soon as possible. The Commissioner and the Director have a shared understanding of the challenges that must be addressed and share a commitment to expeditiously addressing these challenges. In ongoing dialogue with OPM staff over the last several months, we have asked OPM to make three changes to the schedule for ALJ certification to better meet our needs.

First, OPM refreshed the register of eligible ALJ candidates by readministering the examination in 2008 and adding new names. On March 6, 2009, we received a certificate of eligible ALJ candidates.

Second, we have alerted OPM of our plan to hire 400 ALJs, which would bring the total to 1,450 ALJs. In addition, other agencies would hire ALJs from the same register. We have already requested and obtained certificates with enough highly-qualified candidates to enable us to hire about half of the 400. We will continue to work with OPM to ensure that on an ongoing basis the ALJ register contains enough qualified candidates to meet our needs.

Third, we asked OPM to refresh the register no later than November of each year. Doing so would allow us to hire ALJs early in a fiscal year and ensure that the newly-hired ALJs are productive through a greater portion of that fiscal year than if we had to hire ALJs later in that fiscal year.

Finally, OPM has the authority, where appropriate under the applicable statutory and regulatory criteria, to grant dual compensation waivers so that annuitants may be reemployed without salary offset. OPM recently gave us dual compensation waiver authority for specific mission-critical positions which support the work of the ALJs. The authority expires December 31, 2010, and is to be used to meet staffing needs related to the American Recovery and Reinvestment Act. Under our dual compensation waiver authority, reemployed annuitants must perform duties that directly or indirectly reduce the disability and retirement claims backlogs. Alternatively, they must train and mentor recently hired, reassigned, or promoted staff who performs those duties. OPM previously has granted dual compensation waiver authority to reemploy retired ALJs under appropriate circumstances.

8. **Are electronic disability folders being used by all of the hearing offices? Would you say that the use of technology, specifically the use of computers, is a cornerstone of the hearings business process? Are all judges computer literate? If not, how many aren't and what impact does this have on the rest of the employees in that judge's office? What's being done to bring these judges into the 21st century?**

Yes, all hearing offices use electronic disability folders. Electronic folders provide reliable accessibility and allow for more efficient workload processing as work can be moved "seamlessly" among components. It became abundantly clear during our response to Hurricane Katrina that maintaining electronic rather than paper files was a much more efficient, and safer, way to do business. We house the electronic files on remote servers—away from office locations where calamity or natural disasters may damage them.

Our employees must have certain computer skills to function in the electronic case environment. For example, we use our Case Processing and Management System to provide information and to move work through the electronic business process. All new ALJs receive electronic folder training just as all judges received the training when we introduced electronic folders. As in any organization, our employees, including our ALJs, have varying degrees of proficiency in using these tools.

With the impending rollout of the standardized electronic business process, we will provide additional "hands-on" training. Currently we are surveying all ALJs to determine the level of computer proficiency within the ALJ corps. The results of this survey will help determine what additional training is needed to assure that all ALJs can proficiently process our electronic

workloads. We do agree, however, that judges who refuse to use electronic disability folders are slowing justice for claimants. We are actively taking steps to address this issue.

9. **Page 4 of your written testimony includes some stunning numbers about the workloads you face. For example, the SSA verified about 1 billion Social Security numbers (SSNs) last year, which is an amazing 270 times the number of retirement and survivor claims you processed (3.7 million). How much of that Social Security number (SSN) verification caseload is automated, as opposed to comprising a significant employee workload? On page 21 of your testimony, you discuss how you are developing strategies to reduce SSN related workloads. Please provide more specifics on these efforts, including what resources they might free up for other work.**

The vast majority of the Social Security number (SSN) verification workload is automated. However, mismatches resulting from verification processes generate significant work for our field offices.

Currently, State vital records agencies in all 50 States, plus the jurisdictions of New York City, the District of Columbia, and Puerto Rico, participate in the Enumeration at Birth (EAB) process. EAB, which began as a pilot in 1987, allows parents to request SSNs for their newborns as part of the hospital birth registration process. Approximately 96 percent of SSN cards for newborns are issued via EAB.

Our Quick, Simple, and Safe SSN initiative focuses on using automation to improve service and free up field office resources in the enumeration process. Included in that initiative are:

- Decrease the Demand for Replacement SSN Cards: As part of this effort, we are promoting the use of our electronic services and data exchanges, as appropriate, to minimize field office traffic. For example, we have verification systems available to, and data exchanges with, the States and the U.S. military, yet State agencies and military recruiters frequently send persons to our field offices to apply for replacement Social Security cards when they could verify the SSNs on-line more quickly and more easily. Increasing the use of our electronic verification systems would result in decreased demand for replacement Social Security cards.

- Use Video Conferencing Technology: In 2008, we began to test the use of video technology to offer persons—who would otherwise travel long distances to reach a field office—the convenience of filing for replacement SSN cards via video. We have used video technology to conduct claims-related business in the Denver region for over 5 years. In October 2008, we began a pilot in North Dakota to use video technology in the SSN application process and will expand the pilot to Wyoming in April 2009 in order to gather sufficient information to analyze the pilot's success.

- Explore On-Line Replacement Cards: We are developing a process that would allow applicants to complete SSN replacement card applications online. After we have developed an authentication protocol, we will be able to issue some cards without the applicant visiting a field office. Other applicants will still be required to submit documentation by mail or in person at a field office or card center.

- Implement Signature Proxy for SSN Cards: Signature proxy allows applicants for original SSNs and replacement SSN cards to apply for the card without providing a "wet" signature, thus eliminating paper from the SSN application process. The new, redesigned SSN application system called SSNAP will use signature proxy. We will begin the SSNAP phase-in in August 2009. Signature proxy is critical to the implementation of on-line replacement SSN cards.

- Expand Enumeration at Entry (EAE): We are negotiating with the Department of Homeland Security (DHS) to expand the EAE process, in which DHS and the Department of State collect enumeration data and take SSN applications as part of the immigration process.

- Research Auto Cards at Marriage/Divorce: We are researching the feasibility of automatically issuing corrected SSN cards at marriage and divorce. If implemented, the project would involve Federal/State collaboration in which State agencies electronically collect information, such as name changes, necessary to update our SSN records. This project would expand the role of the State vital records agencies.

10. As Commissioner, we know a key priority of yours is ensuring as many of your employees as possible are directly serving the public in order to address the increasing number of new and backlogged claims.

- **How many people deliver direct service to the public?**
  Presently, 55,692 employees (or 86 percent of all employees) are in direct service positions.

- **How many people support those delivering direct service?**
  We have 8,919 employees (or 14 percent of all employees) who support the direct service employees.

- **How many people work in Headquarters?**
  A total of 8,089 employees (or 13 percent of all employees) work at headquarters.

- **How many people work in Regional Offices?**
  A total of 1,948 employees (or 3 percent of all employees) work in regional offices.

- **Are you hiring those who directly serve the public (through field offices, hearing offices, phone centers, etc.) at the same rate as Headquarters and other support personnel?**
  No. We are hiring for direct service positions at a higher rate than support staff positions. Ninety-four percent of our new hires are in direct service positions.

- **What are you doing to ensure as many of your employees as possible are serving the public?**
  Our number one priority is to hire front-line staff who directly serve the public. However, those front-line employees cannot provide the best possible service without sufficient support staff to develop the service delivery tools required to get the work done and to get it done with greater efficiency. Support staff are critical in our efforts to coordinate work,

improve and expand existing automation, and continue development of our telephone and Internet services. Support staff employees also work to improve our in-office service delivery by conducting the analysis to streamline policy, establish Social Security Card Centers, and provide self-help computers and video service delivery. Support staff also conduct administrative tasks, such as processing personnel actions, writing policy instructions, and carrying out budget oversight.

11. The incoming request did not include a Question #11.

12. While over 53% of the SSA staff is eligible to retire by 2017, new OPM estimates indicate 2,100 federal employees expected to retire between 2009 and 2011 will delay retirement due to the economy. How will the SSA's workforce be impacted? Does this change your hiring plans? The current Field Office Management Association President has indicated that this delay provides an increased opportunity for mentoring new employees. Does the agency have plans to improve service delivery training given the larger numbers of experienced staff available?

Our statistics show that the downward trend in the U.S. economy has had minimal effect on retirements in our workforce. Our retirement projections have been within the expected range. Therefore, we do not anticipate that OPM's estimate of delayed retirements across the Federal Government will have a significant impact on our agency.

We base our hiring plans on our budget, on the expected level of our workloads, and on the number of employees whom we anticipate will leave the agency. While the number of employees retiring in FY 2008 decreased slightly compared to the previous 4 years, our workload demands have steadily increased. This year, we plan to hire more employees than we anticipate losing in order to meet our rising workload demands.

Mentor support and on-the-job training are vital to the success of our employees. We mentor all newly-hired employees according to their needs.

In FY 2009, we will begin developing a pilot for transforming entry-level training for direct service employees. We plan on using different training modalities such as Video on Demand, hands on learning, online lessons, and Interactive Video Training. Our plan will increase the use of technology for training as well as address the learning styles of four generations of employees working at our agency.

13. State Departments of Motor Vehicles are moving in the direction of promoting online customer service by charging a small fee for people who continue to seek face to face services. Is that something the SSA is considering? What is the SSA doing, and what options are you considering, to allocate the SSA's resources to deliver efficient customer service?

We have no plan at this time to charge fees for our program-based services, but we understand that Congress may need to consider this option for certain services. We currently charge fees for the work we do to respond to non-program requests by third parties, such as insurance companies requesting disability information or mortgage companies requesting Social Security

number verifications.

In addition to placing employees in key locations, we also have a broad array of initiatives under way to improve our customer service and make it more efficient. These initiatives include efforts to further automate complex workloads, to streamline policies and procedures, to create new and improved Internet and telephone service options, and to improve training for our front-line service employees. We are also using innovative technologies within our field offices to improve customer service. For example, in some offices we have placed televisions in waiting areas to inform the public about our services. In other offices, the public has the option to conduct business on-line with a self-help computer that links to our Internet services, rather than waiting for an available customer service representative. Additionally, Video Conferencing Technology, in field offices and at third party locations provides claims-related service to customers in remote areas and helps handle spikes in office visitor traffic.

14. How do the SSA's technology costs per employee compare with other similar industries? Are there activities that the SSA could automate with relative ease that would free staff resources but due to other priorities have not been done? If so, what are they? Please explain how automation requests for the Agency are prioritized.

In FY 2008, the average information technology (IT) cost per employee was $13,706.[1] The December 15, 2008, Gartner paper "IT Key Metrics Data 2009: Executive Summary" reports average IT spending per employee of $24,823 for the insurance industry and $24,391 for the banking and finance industry.

We focus our automation efforts on major projects requiring substantial IT investments, such as:

- automating the disability claims process;
- developing web-based applications that will increase our ability to provide services over the Internet;
- initiating seamless processing, which will integrate data collection, development, and adjudication; and
- developing health information technology to request, receive, and review health records.

The Information Technology Advisory Board (ITAB) governs the agency's IT investment decisions. The ITAB is chaired by the Chief Information Officer and is composed of the Acting Deputy Commissioner of Social Security, the Chief of Staff, all Deputy Commissioner-level executives, and other executive staff. Its primary responsibilities include prioritizing all requests for automation. The driving forces behind our process include, but are not limited to, return on investment, legislative and court mandates, and audit findings and recommendations.

A request for automation starts as a proposal. Lower level review panels, known as "portfolio teams," review and evaluate the proposals for their anticipated return on investment and to ensure that they will promote the goals and objectives in our Strategic Plan. The portfolio team passes its recommendations to the ITAB for its consideration. The ITAB meets at least four

[1] We computed this per employee cost by dividing our total FY 2008 IT budget ($1,074,204,523) by the total number of full-time, part-time, and State disability determination service employees (78,376).

times a year to create, and then modify, a two-year IT plan based on portfolio team recommendations and to make other IT investment decisions.

15. At the hearing, several individuals mentioned the SSA's need for additional resources to hire and train more workers. The following is from a February 9, 2009 SSA Inspector General document: "We determined that on average 1,450 out of 71,000 SSA employees (approximately 2 percent) had instances of AWOL [absent without leave] each year from 2005 to 2007." Is this a real problem? What steps have you taken to ensure current SSA employees are actually showing up for work and putting in a full and productive day on the job?

We believe the use of AWOL in our agency is not a problem considering the total number of hours worked by our employees compared to the total number of AWOL hours. Our employees work over 135 million hours each year, and approximately 100,000 hours are charged to AWOL. Thus, AWOL hours represent about 0.07 percent of total hours worked.

The February 2009 Inspector General's report stated that employees are charged AWOL for a variety of reasons that fall under three main categories: 1) employees who fail to request leave properly, 2) employees who essentially abandon their positions with no intention of returning to work, and 3) employees who are legitimately ill and have exhausted all available accrued leave, donated leave, and entitlements under the Family and Medical Leave Act.

We continue to address this important human capital issue with managers. Through ongoing training, such as Personnel Management Workshops, provided throughout the year, we advise managers on the various types of leave, proper leave usage, and related discipline to ensure the consistent and accurate application of leave policies agency-wide. In addition, our human resources professionals routinely advise supervisors and managers on methods to deal with employees who have leave-related problems, from the first time an employee fails to comply with leave rules through progressive discipline for AWOL. We also provide information on personnel issues through our online websites as well as Interactive Video Training broadcasts on such topics as "Effective Leave Management." The broadcasts are available to all supervisors nationwide through our websites as well as by Video on Demand.

16. In your oral testimony, you said that the error rate of online applications was not significant. What is the accuracy rate of claims filed online as compared to claims filed in a Social Security office?

We track the accuracy rate of claims by determining whether payments awarded in the application process are accurate based on our policies and procedures. In FY 2008, the overpayment dollar accuracy rates were 99.31 percent for field offices and 98.66 percent for Internet claims. The FY 2008 underpayment dollar accuracy rates were 96.84 percent for field office claims and 96.89 percent for Internet claims. The accuracy rate differences between field offices and Internet claims are not statistically significant. The FY 2008 Internet accuracy data do not include claims filed through iClaims, the new online Social Security benefit application, which was not operational until December 2008.

17. We are very concerned about the deteriorating condition of the National Computer Center (NCC) and your ability to recover all the data you need to process claims and issue checks in a timely manner after a disaster. What is the current and planned backup strategy for the SSA's computer system?

If the NCC fails, there would be little loss of information, and beneficiaries would continue to receive benefits.

We currently maintain disaster recovery capabilities using a commercial hot-site recovery location. Each year we test the process and procedures necessary to recover our IT resources and data. As our data resources continue to grow, eventually the use of a commercial recovery site will no longer be feasible. Because of this limitation, we began construction of the Secondary Support Center (SSC) and initiated the Information Technology Operations Assurance (ITOA) project.

We plan to move part of the NCC's information to the SSC beginning this month. We will continue to create multiple backup copies of critical data on a daily basis. One copy will remain onsite within the NCC, and the remaining copy will be shipped offsite. Thus, should the NCC be damaged or destroyed, the most that would be lost is the last 24 hours of data.

Under the ITOA project, we will copy the data resources of the NCC and the SSC to each other daily. We will equip each site with computing capacity that will allow it to assume the service delivery requirements of the other site should there be a failure. The goal is to provide for recovery of a failed data center within 24 hours and with no more that 1 hour's data loss. The ITOA project is currently underway and on schedule for completion in calendar year (CY) 2012.

While the ITOA project moves toward completion, we are rapidly increasing the SSC's capability to provide additional protection for a loss of the NCC. We will add capacity to the SSC in CY 2009 to allow it to support data recovery operations for the NCC. We will continue to use the commercial hot-site until we can upgrade the SSC and test the recovery process to ensure all critical systems and data are protected.

18. You have been given substantial funds to establish a new NCC. What is the timeframe for its completion? Do you have a cross-component response team ready to respond to inquiries from the General Services Administration and OMB? What can be done to expedite this process and how can Congress help?

We are working with the General Services Administration (GSA) to establish an accelerated project plan to complete construction of the new NCC by October 2013. We project the information systems equipment set-up and integration to be phased in over an 18-month period following construction.

We will work closely with GSA during all aspects of the facility's construction. As integral members of GSA's project team, we provide specific facility infrastructure requirements based on Uptime Institute's Tier 3 standards for data centers and will ensure the building accommodates our IT infrastructure needs for the next 15-20 years.

We oversee all work done by GSA and its contractors through all phases of our construction projects; the new NCC, which we are referring to as the National Support Center, is no exception. Both we and GSA have assigned some of the most highly qualified project managers to the project team. Our employees on the project include Electrical Engineers, Mechanical Engineers, Fire Prevention Engineers, and IT Specialists who participated in the design and construction of the SSC. They have been working on an accelerated schedule for this project since February, when we received the American Recovery and Reinvestment Act funds. In addition, GSA hired specialized construction management consultants and will hire IT consultants to assist on the project.

We appreciate your offer to help, and if we identify any obstacles that we need your assistance to overcome, we will notify you immediately.

19. Please provide the following information for each union that represents employees at the Agency. Also, please provide the number and percent of employees not represented by unions and the positions they hold.

- **The number and percent of employees represented.**

  Four unions represent our employees: the American Federation of Government Employees (AFGE), the International Federation of Professional and Technical Engineers (IFPTE), the National Federation of Federal Employees (NFFE), and the National Treasury Employees Union (NTEU). The following chart shows the number of bargaining unit employees represented by each union.

Union	Number of Bargaining Unit Employees Represented	Percent of Total SSA Employee Population
AFGE	47,849	74.3
IFPTE	995	1.5
NFFE	36	0.1
NTEU	1,025	1.6
TOTAL	49,905	77.5

- **Please provide the number and percent of employees not represented by unions and the positions they hold.**

  There are 14,465 employees who are not represented by unions. These employees represent 22.4 percent[2] of the total employee population. They are divided into two categories:

  - There are 851 employees who would be eligible for bargaining unit coverage based on their duties, but who are not represented because they work in offices with no union representation (i.e., in offices where no union has won an election to become the representative of the employees in the office). These employees represent 1.3 percent of the total employee population.

[2] This number and the 77.5 percent above do not add up to 100 percent because of rounding.

- There are 13,614 employees who are ineligible for bargaining unit coverage based on the duties they perform. These employees represent 21.1 percent of the total employee population.

- **The number who work full-time on union activities (and number of hours worked by year for the last 5 years, including cost).**

  The following chart breaks out, by union, the number of full-time union representatives, the hours they worked, and at what cost.

YEAR	FULL-TIME UNION REPRESENTATIVES	AFGE	IFTPE	NFFE	NTEU
2004	Full-Time Union Representatives	149	2	0	3
	Hours Worked	218,998	2,691		4,581
	Cost	$9,133,021	$112,225		$191,045
2005	Full-Time Union Representatives	122	4	0	4
	Hours Worked	178,645	5,659		6,145
	Cost	$7,721,538	$244,577		$265,583
2006	Full-Time Union Representatives	12	4	0	4
	Hours Worked	19,200	5,863		6,207
	Cost	$922,553	$281,727		$298,224
2007	Full-Time Union Representatives	12	3	0	5
	Hours Worked	19,167	4,370		7,219
	Cost	$938,289	$213,926		$353,394
2008	Full-Time Union Representatives	12	1	0	4
	Hours Worked	20,600	1,480		4,656
	Cost	$1,046,578	$75,191		$236,547

- **The number who work part-time on union activities (and the number of hours worked by year for the last 5 years, including costs and the FTE of that total number).**

  The following chart breaks out, by union, the number of part-time union representatives, the hours they worked on union business, the cost to the agency, and the total number of full-time equivalents (FTEs).

YEAR	PART-TIME UNION REPRESENTATIVES	AFGE	IFTPE	NFFE	NTEU
2004	Part-Time Union Representatives	1,513	149	1	21
	Hours Worked	135,451	12,969	53	13,712
	Cost	$5,648,804	$540,855	$2,210	$571,841
	FTE	65.12	6.24	0.03	6.59
2005	Part-Time Union Representatives	1,502	78	1	18
	Hours Worked	139,229	10,807	113	8,756
	Cost	$6,017,892	$467,088	$4,884	$378,438
	FTE	66.94	5.20	0.05	4.21
2006	Part-Time Union Representatives	1,358	77	1	18
	Hours Worked	140,097	10,857	256	9,015
	Cost	$6,731,593	$521,663	$12,301	$433,187
	FTE	67.53	5.22	0.12	4.33
2007	Part-Time Union Representatives	1,366	78	2	18
	Hours Worked	172,093	11,897	71	6,190
	Cost	$8,424,532	$582,398	$3,476	$303,021
	FTE	82.74	5.72	0.03	2.98

2008	Part-Time Union Representatives	1,280	85	1	14
	Hours Worked	178,006	17,003	64	7,332
	Cost	$9,043,554	$863,834	$3,252	$372,501
	FTE	85.58	8.17	0.03	3.53

- **An overview of how agreements are negotiated and when they are due for renegotiation.**

The current SSA/AFGE National Agreement expires August 15, 2009. The agency's management team continues to prepare for the negotiations based on input from all agency components. Both parties have officially notified each other of their intention to renegotiate the existing National Agreement. Ground-rules negotiations are scheduled to begin on June 2, 2009. Historically, term negotiations with AFGE have taken between 12 to 15 months.

We are also preparing for the upcoming term negotiations with NTEU. We have two contracts with NTEU. One contract covers Office of Disability Adjudication and Review attorneys in the regions and expires on January 31, 2010. The other agreement, which covers some employees in regional offices, expires July 1, 2009. We intend to renegotiate both of these agreements.

The current IFPTE-AALJ contract expires January 31, 2010, and we intend to renegotiate that contract as well.

20. Many concerns have been expressed about the impact a totalization agreement with Mexico could have on Agency workloads and the Social Security Trust Funds. Would you provide the latest specific information about the status of the totalization agreement with Mexico signed by then Commissioner Barnhart on June 29, 2004? What are the specific stages of the approval process and where exactly is this agreement in the approval process?

During totalization negotiations, United States (U.S.) negotiators explained to their Mexican counterparts that U.S. statutes always take precedence over totalization agreements.

After the agreement was negotiated, but before it was signed, Congress enacted the Social Security Protection Act (SSPA) of 2004.[3] Accordingly, we attempted to have Mexico affirm that under U.S. law (and the totalization agreement) we would not be able to pay benefits to persons who have violated immigration law. To date, the Mexican Government has not confirmed that it agrees with our view of the effect that the SSPA has on the totalization agreement.

Five years have passed since the Mexican totalization agreement was negotiated. The terms and Trust Fund costs associated with any agreement negotiated five years ago are likely to have changed.

[3] Section 211 of P.L. 108-203, which applies to alien workers whose SSNs are first assigned after 2003, provides that benefits cannot be paid based on the earnings of any noncitizen unless SSA has issued the noncitizen an SSN indicating authorization to work in the United States.

Once we consider a totalization agreement to be final, the DOS, the National Security Council, and the Office of Management and Budget must then review the agreement. Finally, the White House decides whether to present any such agreement to Congress. If so, the President sends the agreement to Congress.

SOCIAL SECURITY

The Commissioner
June 12, 2009

The Honorable John S. Tanner
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your letter of April 22, 2009, requesting additional information in order to complete the record for the "Joint Hearing on Eliminating the Social Security Disability Backlog," held on March 24, 2009. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Angela Arnett, our Acting Deputy Commissioner for Legislative and Regulatory Affairs, at (202) 358-6030.

Sincerely,

/s/

Michael J. Astrue

Enclosure

Questions for the Record Subsequent to the March 24, 2009, Hearing Before the House Committee on Ways and Means Subcommittees on Social Security and Income Security and Family Support

1. **You stated in your testimony that by the end of the current year, the ALJ-to-staff ratio in SSA's hearing offices will be 4.5 to 1. However, some have suggested that the ratio should be higher – as high as 5.25 to 1 – especially given the importance of working down the backlog quickly. Do you agree that hearing office productivity could be increased if the ALJ-to-staff ratio were higher than 4.5 to 1?**

   Because of the economic downturn, we are seeing an increase in the number of initial disability applications filed, which will ultimately lead to more requests for hearings. In addition to improving our business process and productivity, we will need more administrative law judges (ALJs) and staff to support them to process the projected increase in receipts.

   However, it is not simply the number of staff in a hearing office that determines the most efficient hearing office composition, it is also the mix of employees in the particular office. We believe that, as long as we can provide the right combination of job functions, a ratio of 4.5 support staff – such as case pullers and decision writers – for each ALJ will allow us to continue reducing the backlog. Our goal for this year and into the next is to ensure that all offices have the most efficient mix of staff needed to support the ALJs. The American Recovery and Reinvestment Act (ARRA) funding will help us hire these critical additional support staff.

   With the right mix of critical support staff and the addition of 148 new ALJs whom we are hiring this month, we anticipate seeing an accelerating decrease in the disability hearings backlog. The number of pending hearings has dropped five months in a row and is down for the year, and we should be able to continue to make progress even in the face of the current economic downturn.

   Your timely support of the President's FY 2010 budget will enable us to hire ALJs and hearing office support staff earlier in the fiscal year, which will allow these new employees to complete training and become productive in processing workloads earlier in the fiscal year.

2. **We understand that you have taken measures to better balance workloads between hearing offices, but significant imbalances remain. What further measures will you take to balance hearing office workloads? To what extent are staffing allocations driven by space limitations rather than workloads, and what are you doing to change this?**

   We actively monitor receipts and pending cases and redistribute workloads as we detect imbalances in one hearing office compared to others. We can permanently transfer cases, realign service areas, and temporarily transfer some workloads in order to balance workloads among our offices.

In addition to these workload management techniques, we are developing computer modeling methods to forecast workload anomalies so that we can develop proactive management plans to address changing workloads in our hearing offices. These computer models will enable us to more quickly recognize and respond to potential bottlenecks to alleviate uneven case receipts.

We allocate staff based on not only the location of the most severe backlogs, but also the location of available space. Since we are often unable to increase the size of our offices due to space constraints, redistributing work among our offices is the most effective way to address these imbalances in the short-term.

3. **Do you have a plan to increase Disability Determination Services capacity over the next few years so that SSA can handle both the anticipated increase in incoming disability claims and an increase in continuing disability reviews?**

We are committed to expanding staff in the DDSs and in the federal units that augment the DDSs to help us process the additional initial disability claims we are receiving as a result of the economic downturn. The number of pending initial claims will rise dramatically in a relatively short period of time. In response, we are developing an aggressive strategy to process these claims accurately and efficiently without sacrificing other important disability workloads, such as continuing disability reviews and reconsiderations.

We are still evaluating other options for policy, procedural, and automation changes to help reduce this workload more quickly and expect to release a more detailed plan by the end of the summer.

4. **Testimony from the Consortium for Citizens with Disabilities Social Security Task Force stated that they had "received complaints from representatives that, in some cases, ALJs are discouraging claimants from exercising their right to an in-person hearing." What are SSA's policies in this area, and what actions are you going to take in light of these allegations?**

Claimants have an absolute right to appear in person before an ALJ, and we do nothing to discourage them from exercising this right. On April 17, 2009, the Chief ALJ sent a memorandum to this effect to all ALJs.

We offer claimants the opportunity to participate in hearings using video conferencing. For many claimants video conferences are more convenient and often save them the costs of transportation to the hearing site. In addition, many claimants with certain psychological conditions or mobility limitations prefer video hearings. We expect more claimants to choose this option as we expand our pilot to allow claimants to choose video hearings from their representatives' offices. Video conferencing also gives us more flexibility in scheduling hearings, allows a broader range of expert testimony, particularly in those geographic areas where access to experts is limited, and improves our efficiency by minimizing the need for extensive travel by our ALJs.

5. **You mentioned in your testimony that you would begin posting updates on the backlog on the internet. Would you include data on the actual monthly average processing times for each hearing office in the country, so that Members and the general public can see how their areas are progressing?**

We are currently determining what data would be most useful to post on the internet. We anticipate finalizing our selections and posting this information sometime during June or July. When posted, the data will be available at www.socialsecurity.gov.

In addition, we are preparing individualized pamphlets for each State, detailing our progress through the second quarter of FY 2009 toward reducing the hearings backlog.

6. **At the end of FY 2009, what do you expect the level of pending hearings to be? The level of pending initial claims? How do these compare to the pending level for hearings and initial claims at the end of FY 2008?**

Our original budget estimate was that at the end of FY 2009, we would have about 754,600 cases pending hearings, slightly fewer than our FY 2008 pending level of 760,813 cases. As of the end of May 2009, we are below that number – with 750,601 cases. The level of pending hearings has dropped each of the last 5 months, and if this trend continues through the end of this fiscal year, we expect to continue to drive the pending level lower by the end of the year, probably between 740,000 and 745,000 cases. While we are adjudicating more cases than we did last year, we are still focusing on the oldest hearing cases, which are generally more complicated and take longer to adjudicate. In addition, due to the recession, we are receiving more requests for hearings than we had planned for when we originally submitted our budget.

Due to the economic downturn, we are experiencing an unprecedented rise in initial claims at the DDS level, and we expect to see our highest-ever level of receipts in FY 2009. This increase far exceeds our processing capacity. While we are taking steps to increase our capacity to process this additional work (see our response to Question 3), we will not be able to keep up with the surge of claims. For the January through the end of May period, our receipts are up over 12 percent over last year's, and the number of applications pending in the DDSs has grown over 25 percent, from 556,000 to 702,448.

7. **Labor-management relations at SSA have been increasingly strained. What efforts are you making to improve this situation?**

We maintain ongoing dialogue with all four unions that represent our employees: the Association of Administrative Law Judges/International Federation of Professional and Technical Engineers (AALJ/IFPTE); the American Federation of Government Employees (AFGE), the National Federation of Federal Employees (NFFE), and the National Treasury Employees Union (NTEU). We continue to foster our relationships with the unions through daily interaction, face-to-face meetings,

increased communication, and information sharing with union leadership and representatives.

We have also formed joint union-management committees with three of the four unions – AALJ/IFPTE, AFGE, and NTEU – and established subcommittees to address a number of topics – such as health and safety, judicial technology, etc. – that both union and management officials have agreed are essential for joint resolution. These committees meet at agreed-upon intervals, ranging from one to six times a year. We also initiate and offer briefings for the AFGE General Committee, the IFPTE Labor/Management Committee, and the NTEU Labor Management Relations Committee on an as-needed basis.

8. **In your written statement, you said you were working with GSA to "...expedite opening 10 new hearing offices." We understand that, in some areas with particularly heavy workloads, if there is adequate space in existing SSA facilities such as a hearing office, you plan to increase hearing capacity by temporarily offering dedicated space in such facilities where claimants can take part in video-hearings conducted by ALJs located elsewhere. Is this correct? What are these locations? When do you expect the 10 new hearing offices you described in your testimony to be open? Will all of these hearing offices be full service offices that process appeals and conduct in-person hearings?**

Due to the many obstacles to expanding the hearing offices, the location and size of the hearing offices are essentially the same as they were twenty years ago, even though the demographics of the claimant population have changed dramatically. In our recent expansions, we have considered the changed demographics, which is why we have expanded primarily in the Manufacturing Belt and Southeast.

We are now on track to establish not just 10, but 13 new hearing offices and 5 satellite offices by the end of FY 2010. These full-service offices will be located in areas with the greatest need.

The following table shows our plans for new and expanded facilities.

New Hearing Offices	New Satellite Offices (SO) & Expansions[1]
Atlanta South, GA	Boise, ID – (Permanent Remote Site[2] (PRS) to SO) – New SO
Tallahassee, FL	Sioux Falls, SD – SO Expansion
St. Petersburg, FL	Anchorage, AK – (PRS to SO) – New SO
Fayetteville, NC	Rochester, NY- SO expansion
Akron, OH	Ft Myers, FL - (PRS to SO) – New SO

[1] A satellite office (SO) is located in leased space and provides workload support to its parent hearing office. It is generally staffed with one to three ALJs, decision writers, other support staff, and usually but not always, one management official. Hearings are scheduled and held daily and both video and face-to-face hearings are held if the SO is video equipped.

[2] A permanent remote site (PRS) is generally leased space consisting of one or two hearing rooms, at least one of which is video equipped. Hearings may be held with the judge present or by video.

New Hearing Offices (Cont)	New Satellite Offices (SO) & Expansions (Cont)
Livonia, MI Toledo, OH Mt. Pleasant, MI Madison, WI Topeka, KS Danville, IL/ Portage, IN Auburn, WA Phoenix, AZ	Harlingen, TX – (PRS to SO) – New SO

At the hearing we indicated that we had a preliminary plan to establish a Satellite Office in Gary, IN and we now believe this office will be in Valparaiso, IN. In some regions, depending on the need and the resources available, we established claimant-only hearing sites in local field offices. A claimant-only hearing site generally consists of leased space with one to four video-equipped rooms. Field office employees are available to assist claimants, if necessary. A claimant and his or her representative come to the site for a video hearing, and an ALJ conducts the hearing from a distant hearing office or National Hearing Center. Although some of these video sites are up and running, we are testing various business processes to determine which will best serve our employees and the public. We have also added a larger hearing room at some of these sites in case an ALJ needs to hold a face-to-face hearing.

The GSA space acquisition process takes 15 to 18 months. Various market conditions also affect the acquisition process, such as zoning requirements, building codes, the location and amount of space needed, the vacancy rates in the specific area, community concerns, the economic conditions of the area, and the availability of credit for potential developers and lessors. GSA has committed to SSA that it is fully capable to support the SSA new requirements for additional space.

9. You have testified that the accuracy rate for online applications was comparable to that of claims filed in an office or over the telephone. Because a trained, experienced SSA claims representatives (CR) reviews each claim before it is adjudicated, we would expect these rates to be similar. However, you have also said you are moving SSA towards auto-adjudication, where some claims will be processed to completion and payment without review by SSA staff.

a. What is the pre-review accuracy rate for claims filed over the internet? In other words, how accurate are claims filed over the internet *before* an SSA employee reviews them and recontacts the applicant?

We do not conduct pre-adjudicative accuracy reviews for any claims, including those filed over the internet. Our employees do review every claim for completeness, to make sure we have the information required to adjudicate the claim in compliance with our policies. We also perform management integrity reviews in field offices. After adjudication we perform the ongoing, formal

Transaction Accuracy Review, which ensures our employees adjudicate claims in accordance with agency policy and procedures.

Based on the *Transaction Accuracy Review*, in FY 2008, we found no statistically significant difference in the accuracy rate between field office claims and internet claims. This review did not include claims filed through our new, improved internet application, the iClaim, which was not operational until December 2008. The iClaim application is more user-friendly and includes more guidance for the applicant. Thus, we expect similar, or even better, accuracy rates for iClaim compared to the prior internet application.

b. Does the pre-review accuracy rate differ between retirement and disability claims?

As noted above, this information is not available.

c. What is reviewed in determining whether a claim is "accurate" – is it simply the dollar amount of the benefit paid, or does it extend to reviewing whether SSA policy was correctly applied?

Our reviews look at both the dollar amounts paid and how accurately our policies are applied. A claim is "accurate" when we make the correct payment according to our policies and procedures. A claim is not accurate if our policies and procedures were not correctly applied, resulting in an incorrect award, denial, or payment (either overpayment or underpayment).

d. Does SSA conduct reviews where the entire claim is redeveloped? If so, what is the accuracy rate in this type of review, and do internet claims (both pre-review and post-review by a CR) have the same accuracy rate as in-person or telephone claims?

During our ongoing, formal *Stewardship Review*, we redevelop entire claims to determine if payment is correct. We review a random sample of records of beneficiaries in current pay. The review also involves extensive public contact, including at-home interviews in 25 percent of sampled Title II cases, and 100 percent of sampled Title XVI cases. Since the purpose of the *Stewardship Review* is to provide a payment accuracy measurement for all Title II and Title XVI outlays, we do not identify whether claims were filed in person, over the phone, or over the Internet. Our FY 2008 accuracy rate for overpayments was 99.67 percent and 99.92 percent for underpayments.

This summer, we will begin a new assessment that blends the protocols of the *Transaction Accuracy Review* mentioned in (a) above and the *Stewardship Review*. We plan to pull a sample of recently-adjudicated internet claims each month, make home visits to ensure the claims were filed by proper applicants, and then redevelop the cases to ensure that we paid the correct amount of benefits for the reviewing period.

10. **In your oral testimony, you announced that in May 2009, SSA would introduce a new version of iClaim designed to reduce the need for employees to contact applicants.**

    a. **Is it true that under your current procedures, a CR reviews each claim prior to adjudication to verify that all factors of entitlement are met and all relevant issues are developed? When the new version of iClaim is released, will this change? If not, do you anticipate changing that procedure in some future release? What criteria will have to be met for a claim to be adjudicated without CR review?**

    Currently, claims representatives (CR) review all benefit applications for accuracy and develop for possible entitlements to other types of benefits. If we need to clarify the information provided or if other entitlements exist, the CR will contact the claimant so that he or she can make an informed decision about applying for benefits.

    The May 2009 iClaim enhancement did not eliminate the need for a trained CR to review the claim. We do not anticipate eliminating full claims review by CRs in the foreseeable future. Each applicant has his or her own set of unique, and sometimes complex, circumstances (e.g., earnings, age discrepancies, marriage situations, Medicare/Medicaid coverage issues, etc.).

    Full automation of the adjudicative process for all applicants would require: 1) a high-level authentication policy that minimizes risk and ensures that information housed in our records is disclosed only to the proper persons; 2) 'smart' programming that would allow iClaim to screen applicants as effectively as a CR to determine what types of other benefits they may be eligible for and allow applicants to file for these additional benefits; and 3) conversion of the web-based iClaim application beyond its current function as a simple data-collector to a system with the ability to process an application to pay status.

    b. **Will the new version of iClaim detect all possible protective filing dates? For example, will it detect protective filing based on a statement made on an Social Security Number other than the applicant's own?**

    No, the new version of iClaim considers protective filing dates for the number holder based only on calls to the National 800-Number Network and partially completed iClaim applications. The iClaim software cannot consider other written protective filings or any verbal intent to file, nor can it consider potential entitlement on someone else's record. CRs must still review all possible avenues for protective filing for benefits on the same, or other, SSNs.

    c. **It is our understanding that the iClaim internet filing process does not allow an applicant to compare potential entitlements and benefit amounts if they file on their own versus on a spouse's record, such as would be the case of a retired worker who is also a widow and is eligible to file on**

either record. Is that correct? What fraction of retirees is potentially entitled on the record of a current or former spouse (please provide separate figures for men and women)? Are CRs who review iClaims required to recontact a claimant if there is a potential entitlement on another person's record, to ensure that the claimant is making a fully-informed decision? Please provide a list of situations where an individual applying for benefits using iClaims could be eligible on another record, or would need to choose between two different benefits. Also, please describe whether the iClaim system provides benefit amount information for these other benefits, and, if not, explain how the applicant gets the information needed to make a fully informed decision.

The iClaim application itself does not provide the information that would allow applicants to compare potential entitlements and benefit amounts on their own records to those they might be due on a spouse's or ex-spouse's record. However, the iClaim application contains links to information about various aspects of retirement and disability benefits. In addition, our website also provides fact sheets and links to other sources that explain benefit types and filing options. As dual-entitlement situations are extremely complicated, in these situations a claims representative will contact an applicant to fully explore the options available.

We do not have statistics on beneficiaries who are potentially entitled on other records. In December 2008, 6.4 million beneficiaries received both a retired-worker benefit and a benefit as a spouse or former spouse. Of these, 6.2 million were female and about 135,000 were male. We give applicants the tools to make an informed decision about when they are entitled to receive benefits on more than one record.

The iClaim is not just a retirement application – it acts as protective filing for all benefits to which the applicant may be entitled. Our policy instructs employees to develop for all potential entitlements. Thus, our employees review every iClaim application for entitlement to other benefits and, if other potential entitlements exist, contact applicants to ensure they make an informed decision about other benefits.

There are many scenarios under which applicants may be dually-entitled. The following list includes some of the most common:

- Applicants for retirement or disability benefits on their own record may also be entitled on their spouses' or divorced spouses' records. The iClaim application serves as an application for both benefits.
- Applicants for spouses' benefits via iClaim may also be entitled to retirement or disability benefit on their own record. The iClaim application serves as an application for both benefits.
- Applicants for retirement or disability benefits may also be entitled as parents, widow(er)s, divorced widow(er)s, disabled widow(er)s, or divorced disabled widow(ers). In these cases, a separate survivor application is always necessary; survivor applications are not available through the iClaim process.

d. Will the process for determining whether an individual wants to apply for the Low-Income Subsidy (LIS) for Medicare Part D change in this new release or future releases? If so, please elaborate on what changes are planned and describe how any new process will ensure that any individual who wants to apply for LIS will have the opportunity to do so.

The process will not change. Currently, when an applicant files for benefits via iClaim and is found eligible for Medicare, our automated screening process identifies claimants who are potentially eligible for LIS, and we mail them an application.

Additionally, our online retirement applications contain a link to information about how to apply online for LIS, and our website also explains that applicants may file for LIS through our National 800-Number Network or in any of our field offices.

From Mr Kind:

1. The Milwaukee SSA hearing office has one of the worst wait times – 594 days – and Madison's office has only had two judges. I am glad to hear that Madison will become a full hearing office with 6 judges, but in the meantime, many hearings have been transferred to offices outside the state. In my district, cases in the Eau Clair office were transferred to Los Angeles West last year. SSA's hearing backlog reduction information for state hearing offices only presents information for hearings conducted in Milwaukee and Madison and do not reflect all the hearings requested by Wisconsin residents. I appreciate that my offices still receives updates on those cases that have congressional inquiries, but what are SSA's plans to improve reporting on hearings by state of residency rather than just by hearing office location?

We monitor our ALJs' pending cases on a daily basis to determine which hearing offices are in need of assistance. We use the same monitoring criteria to determine which hearing offices are in a position to provide assistance. To balance workloads, we realign service areas or transfers cases as needed.

For example, the Minneapolis hearing office usually handles hearing requests from Eau Claire, Wisconsin, which is close to the Minnesota border. However, since the daily pending and receipts per ALJ were above the national average in the Minneapolis hearing office and below the national average in the Los Angeles West hearing office, we decided to reassign cases from the Minneapolis hearing office, including cases from Eau Claire, to Los Angeles West. We made this decision in order to improve service for claimants in Wisconsin who had requested a hearing.

Our ability to shift our workloads regionally and nationally provides us with greater flexibility to work down the backlog. Such realignment can lead to anomalies in case load statistics as work is shifted between states. On a regular basis, we do provide written updates to Members of Congress of our initiatives in their states. We monitor hearing offices but do not generate recurring reports for specific areas each office serves. Some locations are served by multiple hearing offices. In order to track cases from these areas, we would need to combine data from multiple offices, which would result in data that could not be ascribed to any specific office. This process would hamper our ability to identify and address problems. Therefore, we have no plans to report on hearings by state of residency.

2. **SSA has seen declines in the number of staff, particularly in field offices, in recent years. I am pleased to hear that new staff members are being hired, but I would like to hear more about where the new staff will be located. SSA expects to hire 5,000 to 6,000 new employees and knowing the details on the distribution of new hires and SSA expansion is important to my office.**

   In total, we will hire over 7,000 new employees in FY 2009, which includes both new positions and replacements for employees who left while we were operating under a continuing resolution. The majority of these new hires will go to our front-line operations – our field offices, call centers, hearings offices, and the state agencies where we provide direct service to the public. Hiring will be spread throughout the country, with approximately 3,500 hires for our field offices, teleservice centers, and processing centers; 1,500 hires for our hearing offices; and 1,900 hires for the State DDSs. We are also planning to hire another 600 employees at the end of FY 2009 in the DDSs, as advance hires for FY 2010.

   Since March, when we received ARRA funding, we have hired a total of 1,761 new employees and the DDSs have hired 273 new employees. Our Office of Disability Adjudication and Review has hired 684 employees, including seven located in Wisconsin.

3. **The testimony from Mr. Bertoni of the Government Accountability Office highlights a dramatic increase in the backlog since 1999. In 1999 and 2000, hearings accounted for a minority of the backlog, while today they count for a majority of the backlog. The SSA plan highlights Quick Disability Determination as one method to mitigate backlog at the hearings level. What other approaches will SSA take to stop the backlog before it gets to the hearing level?**

Modernizing the disability process allows us to award benefits as early in the disability determination process as possible, preventing cases from unnecessarily adding to the hearing backlog. This modernization includes:

- eCAT: Early indications show that our electronic claims analysis tool (eCAT) improves the quality of disability determinations by helping adjudicators work through the policy aspects of claims adjudication to yield consistent, policy-compliant outcomes and better service to claimants. We expect the use of eCat will produce well-reasoned determinations with easy-to-understand explanations of how we reached our decision. We believe that eCAT, currently a pilot in Virginia, Connecticut, Colorado, and Michigan, has the potential to improve productivity and be a valuable training tool for new adjudicators. We plan to expand eCAT to Louisiana in June.

- Electronic Screening: This screening allows us to quickly identify and allow cases involving diseases and conditions that are clearly disabling.

- Electronic Medical Records: A new paradigm for accessing electronic medical records allows us to make exponential improvements in the speed and quality of our decisions. Chasing down scattered paper medical records requires an enormous amount of time and results in additional cost, error, and delay. We plan to expand this highly successful pilot.

- Integrated Disability Process: This process will ensure that we apply our disability policies and procedures consistently. As part of this initiative, we will:
    - improve the collection and use of information found in medical source statements;
    - streamline the development of a claimant's past work;
    - improve our handling of subsequent disability applications filed while an earlier application is pending before the Appeals Council; and
    - unify our core disability policy training so that all disability case adjudicators are trained with the same materials.

- Update and Expand the Listing of Impairments: We are updating and expanding our medical listings to reflect advances in medicine and to improve the accuracy and consistency of disability determinations. We plan to update all of our listings by the end of FY 2010 and at least every 5-7 years thereafter. We also plan to expand the listings to include rare diseases and conditions that clearly represent permanently disabling conditions.

- Occupational Information System: We are developing a new occupational information system to replace the Dictionary of Occupational Titles (DOT). The DOT, which was created by the Department of Labor (DOL), has been a cornerstone of our disability policy. However, the DOL has not updated the DOT since 1991 and has no plans to do so. DOL's replacement for the DOT, O*NET,

does not serve our purposes. We must have accurate vocational information so that we can base our disability determinations on current job requirements.

In December 2008, we established the Occupational Information Development Advisory Panel to advise us on creating an occupational information system tailored to our disability policy. This panel held meetings in February and April and has two more meetings scheduled for this year. In FY 2010, we will begin to identify the physical and mental abilities and skill levels required by current occupations, develop the means of gathering occupational information, and research assessment of residual functional capacity.

We also awarded contracts in August 2008 to help us evaluate an outside entity's compilation of updated occupational information that is similar to the DOT. An independent third party will evaluate this information and assess whether the product meets our criteria for use in our disability programs. If the product meets our criteria, we could use this updated occupational information while we continue our work to develop a new occupational information system tailored for SSA.

From Mr. Yarmuth:

1. **What explanation do you have for the increase in the average processing times (in days) for the hearing office in Louisville, KY from 449 days to 526 days over the past year?**

   There are a number of reasons why the average processing time has increased in Louisville. One of the chief ways that we are working down the backlog is by shifting workloads among hearing offices, moving cases from some of the offices most in need of assistance to others that have some capacity to help. This initiative helps balance our workloads. In FY 2008, we transferred 826 cases from the Cincinnati, OH hearing office to the Louisville, KY hearing office. Cincinnati's daily pending and receipts per ALJ were well above the national average, while Louisville's numbers were well below the national average. Due to the transfer, the number of pending cases, average processing time, and monthly receipts have increased for the Louisville hearing office.

   In addition, the Louisville office has focused on processing cases that have waited the longest for a hearing decision. These cases are often very time-consuming and complex, but it is imperative that we process them. Through April 2009, the Louisville hearing office decided and closed 1,016 (91 percent) of its targeted 850-day cases. Processing a large number of older cases increases average processing times.

   Finally, the Louisville hearing office lost one ALJ in May 2008 and gained a newly-hired ALJ in July 2008, whom we expect to become increasingly productive this year. The loss of an experienced ALJ affected pending times as the experienced ALJ decided 224 cases during the first six months of FY 08, an average of 37.33 dispositions per month, while the new ALJ was in training.

2. **Given this increase, what is the Administration doing to alleviate the problem in Louisville?**

In addition to hiring the new ALJ, the Louisville hearing office also gained an experienced ALJ in April 2009. Eight ALJs now serve the office, up from seven at the close of the FY 08.

Based on recent analysis of pendings and receipts, we reversed the workload realignment in the Louisville hearing office effective March 20, 2009. We expect this action to reduce the pending cases and monthly receipts for the Louisville hearing office.

3. **What change should we expect to see in the averaging processing time in the upcoming year?**

Due to the increase in hearing requests and our continued focus on completing aged cases, we estimate that our processing time will be about 516 days and our pending will be about 740,000 to 745,000 cases at the end of FY 2009.

This year we budgeted for an average processing time of about 516 days. But at present, we are doing much better than that. Preliminary data shows a current average processing time of about 494 days through this fiscal year to date. We are beginning to see an increase in claims due to the economic downturn. We will continue our focus on the most aged cases which may lead to a slight increase in average processing times toward the end of the fiscal year. We expect to continue our progress with the backlog reduction plan in FY 2010, focusing in particular on decreasing pending case levels and improving average processing time.

4. **What is different between the hearing office in Dallas North, TX and Louisville, KY that would contribute to the large difference in average processing time (155 days)? What enabled the Dallas north office to decrease its processing time over the past year by 66 days?**

In general, the Dallas North hearing office has a greater proportion of "less-aged" cases, those cases pending less than 270 days, than does the Louisville hearing office. These less-aged cases tend to be easier to clear and, thus, improve an office's average processing time.

The Louisville hearing office has also cleared more aged cases than Dallas. The Dallas North hearing office has closed 750 aged cases, (about 20 percent of its total dispositions) compared to the Louisville HO which has closed 1,016 aged cases (over 40 percent of its total dispositions). The emphasis on clearing these aged cases results in increased average processing time in the Louisville office, but better serves claimants who have waited years for a decision.

From Mr. Pomeroy:

1. **Commissioner, I recall your first hearing before this subcommittee. I appreciate your assurance that SSA has a plan to eliminate the backlog by 2013 which still leaves way too many disabled Americans waiting for the benefits that they have earned through years of work. Congress has provided SSA with additional funding in the last two budgets and in the Recovery package over and above what you requested to address this urgent need. I personally have pushed OPM to deliver two registers with an adequate number of Administrative Law Judge (ALJ) candidates for SSA to hire. I learned from the experience with the frozen ALJ register that the Subcommittee needs to verify progress. *Fiscal Year 2008 Annual Report for ODAR* included a small graph showing projected hearing pending levels decreasing to about 400,000 in a straight line from its peak. So far the improvement for the additional funding has not been significant. Please provide the Subcommittee with details on the plan's targets for each of the next five fiscal years for the following:**
    a. **Year End Pending Case Level**
    b. **Dispositional Goal**
    c. **Average Hearing processing Time for the year**
    d. **ALJ Staffing Level, and**
    e. **Number of Support Staff and ratio per ALJ**

The following table details the plan's targets regarding pending level, dispositions, processing time and average ALJs On-Duty:

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Year End Pending Case Level	754,600	726,800	676,900	580,000	454,300
Disposition Goal	647,200	725,800	785,900	795,900	795,700
Average Hearing Processing Time for the Year	516	508	476	416	326
Average ALJs On-Duty	1,182	1,341	1,442	1,442	1,442

Hearings received beginning October 2013 will have an average processing time of 270 days, which we believe is the optimal processing time. In addition, for FY 2010 through FY 2013, our plan supports a support staff ratio per ALJ of at least 4.6 to 1. Of course, full funding of our plan is crucial to achieving our hearings goals.

2. **How many full-time equivalents (FTEs), in addition to current staffing levels, would be required in the Field Offices to address all their responsibilities? To reach these staffing levels how many more FTEs would the Field Offices require above the level of hiring that you are planning for FY 2009? How many hires above replacement level would the Field Offices receive if SSA is funded at the**

full FY 2010 President's Budget request of $11.6 billion? Will you be able to place additional employees in every Field Office nationwide?

In FY 2009, we will hire over 6,000 new employees between March and the end of this fiscal year, replacing all staffing losses and adding critical new positions. We will assign the majority of these new employees to our front-line operations, where they will directly assist the American public. Although these new employees will help us improve the overall level of service, we will have a backlog of approximately 900 work years in post-entitlement work in FY 2009, i.e., actions we take after a claimant is awarded such as changes of address, stewardship reviews, etc.

If we are funded at the full FY 2010 President's Budget, we will hire approximately 5,800 employees in FY 2010, replacing all staffing losses and filling 1,300 new positions, with the majority of the hires working in front-line positions. We will add 600 new workers in the DDSs and add about 700 new employees in the hearings offices. We will place these employees in the offices with the greatest need. Most field offices have received or will be adding additional staff, but not all will, due to changes in workloads, real estate constraints, and other issues.

3. **What are your plans to address the high telephone busy rates and long waiting times in Field Offices? What is the resource level Field Offices need to address the high telephone busy rates and long waiting times?**

We are committed to meeting standards for good customer service, although it is difficult to set fixed goals for an acceptable level of busy rate or waiting time. External factors that drive our workload include: funding, economic conditions, call volumes, and other factors. In support of our commitment to improve service, we hired 628 new national 800 number teleservice representatives in FY 08, and we plan to hire over 550 more this fiscal year. These additional national 800 number hires will provide us with increased answering capacity and enable us to begin handling calls to our field offices that would otherwise have encountered a busy signal.

In addition to manpower, we need to harness new technologies to improve our service. We will use automation to improve our field office telephone service and support our website visitors. Our current telephone system has reached the end of their lifespan and is being replaced. The new system will provide a unique toll-free telephone number for each field office and allow callers to contact their local office from anywhere in the country without long distance charges.

We are expanding our Field Office Automation (starting this year with 119 offices) and Forward-on-Busy projects (soon to be in 200 field offices) to additional field offices over the next 3 years. Expanding these projects will allow people who call our field offices access to services now available on the national 800 number.

4. **You have mentioned the increase in the number of Internet Social Security claims in the last year. We have heard of people leaving the Field Offices without a claim being taken because they are encouraged to file on the Internet rather than waiting. Is this occurring in Field Offices? You indicated that**

Americans should be able to choose how they receive assistance from SSA whether it is in person, over the phone, or over the Internet – and shouldn't all of these choices be timely, efficient, and accurate?

We do not refuse service to anyone visiting local field offices. Our employees inform visitors of the available service delivery options: in-person interview, with or without an appointment, online, or over the telephone. We work diligently to make each option as timely, efficient, and accurate as possible.

5. **Your plans indicate moving the Social Security Administration to a more high tech environment with at least half of SSA claims being filed via the Internet. What do you see as the role of Field Offices in the future as you increase the number of Internet claims? Do you see Field Offices being closed and SSA consolidating operations to handle Internet claims?**

We do not foresee closing or consolidating any field offices as a result of internet use, even if that use increases dramatically. In fact, we continue to open new offices. Over the next few years, we will be opening three new field offices in Rio Rancho, NM, McAllen, TX, and Mechanicsville, MD and several new Social Security card centers in Houston, TX, Minneapolis, MN, and Philadelphia, PA. We continue to expand and improve our service delivery options for the public, including the ability to file claims online, and are pleased with the public's response. As we move into the future, increasingly our claimants will want to search for information and pursue claims online.

Traffic in our field offices is increasing due to the large number of eligible retirees and the increasing number of disability applicants. Alternative service options offer convenience to our claimants and save us valuable resources by reducing traffic in our field offices to the extent possible. With less traffic in the field offices, our technicians can devote more time to reviewing and processing claims, as well as providing in-person and telephone service for those who wish to use those types of service.

SOCIAL SECURITY

The Commissioner

June 30, 2009

The Honorable Sam Johnson
Ranking Member, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Johnson:

Thank you for your May 20, 2009, letter requesting additional information to complete the record for the hearing on "SSA's provisions in the Recovery Act," held on April 28, 2009. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Angela Arnett, our Acting Deputy Commissioner for Legislative and Regulatory Affairs, at (202) 358-6030.

Sincerely,

/s/

Michael J. Astrue

Enclosure

Questions for the Record Subsequent to the April 28, 2009, Hearing
Before the House Committee on Ways and Means
Subcommittee on Social Security

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1. **We are interested in knowing more about the marked differences that constituents can expect to see in the field offices based on the funds provided in the America Recovery and Reinvestment Act. With the hiring of front line staff can constituents expect reduced wait times? Answered phones? Increased availability for claim appointments? We recognize the training takes some time before new employees will have a noticeable impact, but once they are fully trained, what specific service improvements can be expected and what performance measures will be used with respect to these improvements? Please provide a timeline for improvements and metrics by which progress can be judged.**

New hires funded by both ARRA and our regular full year appropriation will make a real difference in the service we provide to the American public. We will deploy the majority of these hires to our front-line operations throughout the country, with approximately 3,500 hires for our field offices, teleservice centers, and processing centers; 1,500 hires for our hearing offices; and 1,900 hires for the State DDSs. We appreciate the funding that has permitted us to carry out this hiring.

We are moving quickly to hire additional employees using the ARRA funding. Between March, when we received ARRA funding, and June 19, 2009, we have hired all 1,530 field office and teleservice center employees and 445 of the 585 hearing office employees made possible by ARRA funds. During this same period, the State DDSs have hired 273 of the 300 additional employees they will bring on board with ARRA funding.

The $500 million provided by the ARRA will help us address our rising workloads caused by the economic downturn and the leading edge of the baby boom retirement wave. In addition to hiring more staff, we are using the ARRA funds to provide for more overtime. These efforts will allow us to process 50,000 more initial disability claims, 243,000 additional retirement claims, and 37,000 additional requests for hearing this fiscal year.

As you acknowledge, it will take time for our new employees to become fully productive. We considered this learning curve and improved productivity when developing our Key Performance Targets and Annual Performance Plan measures for FY 2010. These targets include processing significantly more disability claims and continuing to process more retirement claims.

As part of the FY 2010 measures, we will also improve our National 800 number response time. We closely monitor key indicators such as telephone busy rates and

waiting times and make the necessary adjustments on a day-to-day basis in order to optimize our service. Our new hires will be instrumental in helping us reduce both busy rates and waiting times for callers, and helping us improve service to field office visitors.

2. **In her oral testimony, Ms. Glenn-Croft stated that the National Computer Center (NCC) would not reach its maximum electrical capacity before the Secondary Data Center in Durham would be able to handle the NCC's workload. However, the Lockheed Martin feasibility study indicates that the NCC could reach its maximum electrical capacity as early as 2011, and the Inspector General's written testimony indicates that the Secondary Data Center in Durham will not be fully operational until 2013. Please provide a timeline that includes all relevant dates regarding data, electrical, and production capacity at the NCC, the Secondary Data Center in Durham, and the new National Support Center (NSC). Please be as explicit as possible in the descriptions for this timeline in order to remove any ambiguity in phrases such as "critical workloads", which were used in written testimony.**

   We are confident that we will be able to provide sufficient electrical distribution to the NCC operational workloads until we transition from the NCC to our new National Support Center (NSC). Based on recommendations contained in Lockheed Martin's June 2008 report, we initiated several improvements to the NCC building infrastructure and systems, extending our ability to distribute electrical power to the IT equipment until the NSC is fully operational. We plan to complete these improvements by calendar year 2010. Additionally, by early calendar year 2010, we will have enough hardware and software in the Secondary Data Center (SDC) in Durham that, should there be a catastrophic event in the NCC, we would be able to bring up in Durham all agency claims and data processing systems used to serve retirees, disabled persons, dependents, survivors, and aged individuals.

   We are taking a number of proactive steps to ensure that we continue to have sufficient computing capacity. From an IT perspective, we are maximizing the number of workloads that we can run on the mainframe computer platform. This allows us to consolidate our software onto fewer mainframe computing systems. To accomplish this, we have tripled our mainframe processing capacity over the past few years, while maintaining the same space and power requirements. In addition, for workloads that run on other server platforms, we will employ shared use technologies that allow us to use one server to process multiple workloads. Shared processing technology will reduce our need for more stand-alone servers, thus optimizing the NCC's remaining electrical distribution capacity.

   We have included a placeholder in our budget for renovation projects. Accordingly, if the data center in the NCC reaches electrical distribution capacity, we will have the funds needed to move staff out of the building and add more IT equipment to other floors.

In addition, we are continuing our preventive maintenance schedule to ensure that the NCC infrastructure systems remain fully operational and that we identify any potential problems early.

Timeline of NCC Updates and Development of Durham and NSC:

In order to ensure that the NCC will keep running through calendar year 2015 when the new NSC will be ready, we have taken, and plan to take, the following actions:

- In 2008, we expanded the NCC 3rd floor data center by approximately 4,000 square feet. This expansion freed up several additional circuits to provide power for approximately 80 server cabinets.

- In May 2009, we moved our medical evidence repository to Durham. By the end of calendar year 2009, we will have moved additional functions to Durham and removed approximately six tape silos from the NCC. We are removing the old silo equipment in order to install newer storage systems with a much smaller footprint. We will split these new silos between the NCC and Durham. Replacing the silos will provide an additional 4,000+ square feet in the NCC and free up additional circuitry for more server racks.

- In fiscal year 2009, we plan to submit a reimbursable work authorization to GSA to install in the NCC 3rd floor data center two new 480 volt uninterruptible power supply risers for computer equipment and two 480 volt general house power risers for additional cooling equipment. This project should be completed in calendar year 2010 and will provide additional electrical capacity to the 3rd floor data center. This power will be available for additional power distribution units, which will provide several hundred additional circuits to 110/208 volt equipment.

- In fiscal year 2010, we will replace the riser panels, which will increase the electrical circuits on all floors of the NCC, including an additional 256 circuits to the 3rd floor data center. We will also have the option of installing up to 20 additional Remote Distribution Centers to provide several additional circuits. The project will take place over the following 3-day weekends: Columbus Day weekend (10/2009); Presidents' Day weekend (2/2010); Memorial Day weekend (5/2010); and Independence Day weekend (7/2010) (contingency if needed).

- By October 31, 2010, we will have converted employee space into data center space at the SDC in Durham.

- Site selection and design/construction of the new NSC is on schedule. Major milestones are:
    - purchase land by March 2010;
    - award a design/build construction contract by March 2011;
    - complete construction by October 2013.

3. **Please provide comprehensive timelines indicating when each of the NCC's functions will be brought back online if a failure were to occur today; in 6 months when the Secondary Data Center will be able to process about half of the SSA's production workloads, as indicated in written testimony; and on the date that the Secondary Data Center is able to provide full backup and recovery for the SSA's data and daily processing needs.**

   In our disaster recovery exercise this year, we were able to restore all of our essential computing functions within 7 days, using existing systems.

   We have expedited the activities necessary to recover our operational workloads at the SDC if the NCC were to experience a disaster. Based on our current estimates, once we have completed the accelerated disaster recovery environment in the SDC, we will reduce our recovery time to approximately 5 days. By early calendar year 2010, the SDC will be equipped to handle our current disaster recovery needs, with enough capacity to process half of the agency's production workloads. In addition, the accelerated disaster recovery initiative will provide us with a guaranteed recovery facility at the time of a disaster and will provide a single location for complete recovery and transition back to normal operations. Although we are working aggressively to realize this goal, the timeline for completion is contingent upon our ability to procure and deploy all needed equipment.

   Our longer-term goal is to recover all essential functions and systems associated with our primary mission in either data center within one day and to lose no more than one hour's worth of data in a disaster. We plan to have this capability in place by 2012.

4. **In oral testimony, Ms. Glenn-Croft assured the Subcommittee that the NCC will continue to operate through 2015. Yet, Lockheed Martin reported that the manufacturer of the Uninterruptible Power Supply (UPS) indicated that the failure of any large component could not be repaired and that UPS maintenance contract support will end in 2012. What will happen if there is a failure of a large component?**

   As recommended in the Lockheed Martin study, we have procured the spare parts needed to maintain and repair the UPS system. We have a contract in place with our current vendor through fiscal year 2012 for any necessary repairs to the UPS. When the current contract expires, because we have the spare parts, we will be able to execute a new maintenance contract through fiscal year 2015.

5. **How has the Information Technology Advisory Board (ITAB) functioned in the absence of the Chair? What meetings have been held and what issues have been addressed? Please describe how information technology (IT) projects and**

expenditures are prioritized for review by the ITAB. Is there any written Agency policy or criteria that are applied to ranking IT budget priorities prior to the recommendations submitted to the ITAB?

The Deputy Commissioner of Social Security and the Chief of Staff co-chair the ITAB. The Deputy Commissioner for Systems provides all administrative support.

Meetings are generally held quarterly, with additional meetings called when necessary. Every regular meeting includes an update on the progress of major investments and the health of projects underway. During these meetings, the ITAB provides guidance on the investment of IT resources in support of strategic priorities and makes decisions related to the allocation of resources to specific projects.

The ITAB organizes IT investments into portfolios aligned with our strategic objectives. Each portfolio is led by an executive sponsor, the Deputy Commissioner of the component responsible for the same strategic objective in the Agency Strategic Plan. A portfolio manager and staff provide necessary support to each Deputy Commissioner sponsor. Before submitting a project to the ITAB, portfolio managers, pursuant to written guidelines, assess projects based on quantitative value (return on investment), qualitative value (benefit value score), and the degree to which a project meets a critical agency need.

6. **Who from the SSA is on the team working with the General Services Administration (GSA) on building the new NSC? Who is in charge from the SSA? What role will the ITAB play regarding the new NSC?**

   The Deputy Commissioner for Budget, Finance and Management and the Deputy Commissioner for Systems are in charge of the NSC initiative. They are supported by a project executive, project manager, and technical support staff.

   The Deputy Commissioner for Budget, Finance and Management provides executive leadership for the building phase of the NSC. Once the building is ready, the Deputy Commissioner for Systems will provide executive leadership during installation of equipment and systems.

   We have allocated a very limited number of resources for the development of the requirements for the NSC and will brief the ITAB on the status of the project status in advance of any request for IT resources.

7. **What role has the Future Systems Technology Panel (FSTP) played in analyzing the problems that exist at the NCC? What role is the FSTP playing regarding the new NSC?**

We analyzed the NCC problems prior to the establishment of the Future Systems Technology Advisory Panel, so the panel was not involved with the initial determination that a new data center would be needed.

The charter of the advisory panel states that the panel will "provide the Commissioner of Social Security independent advice and recommendations on the current status of SSA's systems technology and a road map to assist the Agency in determining what future systems technologies may be developed to assist SSA in carrying out its statutory mission."

The members of the panel have recently formed subcommittees to address various agency issues. One subcommittee will address data center migration and the planning and flexibilities needed for a new data center. The panel may provide advice or recommendations regarding the capabilities of the new data center. At present, the panel has just begun its efforts, and we have not yet received advice or recommendations regarding the new data center.

8. **Who is in charge of the Secondary Data Center in Durham? To whom do they report?**

   Our Deputy Commissioner for Systems is in charge of the Secondary Data Center. He reports directly to the Commissioner of Social Security.

9. **When the NSC is fully operational, what will happen to the former NCC building? Will it still be used? For what purposes?**

   We expect to use the NCC building for office space for agency staff, but have not yet determined the specific purposes the building will support. We will work with GSA to schedule renovations for the NCC along with the other aging buildings on our campus, through the Federal prospectus request process to obtain funding from the Federal Building Fund.

10. **The FY 2009 appropriation included funding (a base appropriation of $264 million and an adjustment for an additional $240 million) to conduct continuing disability reviews. Please provide a specific plan of what CDRs will be conducted, by which component, and the status of all actions relative to the completion of this work.**

    The FY 2009 appropriation provided us with a total of $504 million for two important program integrity workloads – CDRs and Supplemental Security Income (SSI) non-medical, i.e., resource and income reviews among others, redeterminations of eligibility. We plan to use these funds to conduct 329,000 full medical CDRs and 750,000 mailer CDRs where we ask the beneficiary to provide updates on their

impairment, medical treatments, and work, for a total of 1,079,000 periodic medical CDRs. Our field offices, processing centers, and the State DDSs process this work. In addition, our field offices will conduct 1,711,000 SSI redeterminations.

Through the end of May we have completed 188,000 of our full medical CDRs, 568,000 of our mailer CDRs, and 1,208,000 SSI redeterminations.

11. **In September 2008, the Government Accountability Office (GAO) issued a report on the Agency's management of information technology. The September 2008 report suggested that a large percentage (58%) of the IT budget expenditures are not considered managed investments under the Agency's Capital Planning and Investment Control (CPIC) process and are never reviewed or authorized by the ITAB. Is that still true? The GAO also observed that the CPIC process has not been officially approved by the SSA's management. Why hasn't this happened?**

The GAO report recommended that we "develop and implement policies and procedures for managing IT acquisitions as investments." In our response to GAO on this recommendation, we explained that our existing information technology systems (ITS) budget development process already treats IT acquisitions within an investment management framework, though not one described by GAO's Information Technology Investment Framework. We agree, however, that we can further integrate the ITS budget development process into the ITAB-centered investment management process.

The ITAB is responsible for allocating human resources, both government personnel and contractors, ensuring that our investments support our strategic goals. By contrast, the 58 percent of the IT budget to which the GAO referred focuses on acquisitions, as opposed to work years. This portion is primarily spending on the infrastructure required to support the strategic investments that the ITAB advances. A substantial portion of these funds go to nondiscretionary recurring costs such as phone bills and maintenance contracts for hardware and software.

The Chief Information Officer, working closely with the Deputy Commissioner for Systems and his executive staff, is responsible for this portion of the IT budget, consistent with the Clinger-Cohen Act of 1996, 40 U.S.C. 11312-11313 and 44 U.S.C. 3506. They ensure that the IT infrastructure is capable of fully executing the ITAB decisions and supporting the agency's programmatic systems.

The 58 percent of the IT budget not covered by the ITAB is subject to the CPIC process with significant oversight by the Office of IT Investment Management. Since 2002, we have documented our CPIC process in our Information Resources Management Strategic Plan, and we recognize it as the guiding principle for IT management. The process reflects the requirements of the Clinger-Cohen Act that the

head of each executive agency implement a "process for maximizing the value, and assessing and managing the risks of IT acquisitions of the agency."

SOCIAL SECURITY

The Commissioner

July 23, 2009

The Honorable John S. Tanner
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for Kathryn Olson's June 17, 2009, letter requesting additional information to complete the record for the May 19, 2009, hearing on our employment support programs for disability beneficiaries. Enclosed you will find the answers to the questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Angela Arnett, our Acting Deputy Commissioner for Legislative and Regulatory Affairs, at (202) 358-6030.

Sincerely,

/s/

Michael J. Astrue

Enclosure

Questions for the Record
For the May 19, 2009 Hearing
On SSA's Employment Support Programs for Disability Beneficiaries

Questions from Chairman John S. Tanner

Ticket to Work Program

1. **Please provide the following data regarding participation and outcomes for the Ticket Program and state Vocational Rehabilitation (VR) Agency services. Note that the term "employment network" is intended to include both a non-VR employment network and a state VR agency acting as an employment network.**

   a. **The number of beneficiaries who currently either have a ticket assigned to an employment network or are receiving services from a VR agency under cost reimbursement.**

      As of May 31, 2009, there were 269,732 beneficiaries who had assigned their tickets to an employment network (EN) or were receiving services from a VR agency under cost reimbursement.

   b. **The number of beneficiaries currently receiving services from a VR agency under cost reimbursement.**

      As of May 31, 2009, there were 236,112 beneficiaries receiving services from a VR agency under cost reimbursement.

   c. **The number of beneficiaries who currently have a ticket assigned to an employment network.**

      As of May 31, 2009, there were 33,620 beneficiaries who had assigned their tickets to an EN.

   d. **Of those beneficiaries who currently have a ticket assigned to an employment network, the number who assigned their ticket since the new regulations became, effective in July 2008.**

      As of May 31, 2009, there were 11,102 beneficiaries who had assigned their tickets to an EN since the new regulations became effective.

e. **Of those beneficiaries who currently have a ticket assigned to an employment network, the number and percentage who have worked (e.g., the employer network has received at least one milestone payment), and the number and percentage who are no longer receiving cash benefits.**

As of May 31, 2009, there were 3,960 beneficiaries (or 11.7 percent of all beneficiaries who had assigned their tickets to an EN) who had worked, and 2,183 beneficiaries (or 6.5 percent of all beneficiaries who had assigned their tickets to an EN) who were no longer receiving cash benefits.

f. **The number of employment networks currently participating in the Ticket program.**

As of May 31, 2009, there were 1,294 ENs participating in the Ticket program.

g. **The number of employment networks participating in the Ticket Program one year ago (including VR agencies acting as employment networks, but not VR agencies providing services to Ticket holders under cost reimbursement).**

On May 31, 2008, there were 1,190 ENs participating in the Ticket program.

2. **Since the new regulations became effective, how many beneficiaries have participated in the new Partnership Plus option? What preliminary outcome data is available?**

Since the new regulations became effective, 912 beneficiaries have participated in the new Partnership Plus option. Out of this group, 107 beneficiaries have engaged in work activity that has resulted in EN payments.

These figures represent only preliminary results. To implement Partnership Plus, State agencies must train staff, change their policies and procedures, and revise relevant materials. Furthermore, the average VR program takes two years to complete. Therefore, we will need two to three years to fully implement Partnership Plus.

3. **What are SSA's plans for ongoing evaluation of the Ticket Program to assess the impact of the new regulations?**

We have contracted with Mathematica Policy Research (MPR) to develop two Ticket program evaluation reports, and expect MPR to complete these reports in 2010 and 2011. These reports will assess the experiences of the agency, providers, and beneficiaries with the Ticket program under the new regulations. The reports will include the following:

Participation Analysis. An assessment of participation in the Ticket program over

time, assignments to ENs and SVRAs, and differences in participation (rates and characteristics of participants) under the new Ticket regulations.

Process Evaluation. Will use survey, administrative, and qualitative data to assess our implementation of the new Ticket regulations, service providers' views on the new regulations, changes in provider participation and revenue due to the new regulations, beneficiaries' knowledge of the Ticket program, and beneficiaries' experiences with the program under the new regulations.

We will include information about beneficiary experiences with the Ticket program under the new regulations (information sources, Ticket assignment process, interactions with providers, and satisfaction with the program) only after the data from the fourth round of the National Beneficiary Survey become available. Therefore, we will include this information only in the 2011 evaluation report.

Outcome Evaluation. Will use survey and administrative data to assess the service use and employment outcomes of Ticket participants under the new regulations and compare them to the outcomes of Ticket participants under the original program rules. Outcomes of interest include: types and intensity of service, employment, wages, monthly earnings, use of our work incentive provisions, and months off the disability rolls due to work. We will include information about the outcomes of participants under the new regulations only after the data from the fourth round of the National Beneficiary Survey become available. Therefore, we will include this information only in the 2011 evaluation report.

Impact Evaluation. Will assess the impact of the new Ticket regulations on service enrollment, employment, and SSA benefit receipts. We are taking a multifaceted approach to assess the impact of the new regulations. Since the Ticket program is already a nationwide program, estimating this effect is challenging. We will need to consider other factors, such as local economic conditions, that influence Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) beneficiary work activity. We are forming a Technical Support Group of evaluation experts that will help us develop the details of our approach and will ensure we calculate the estimate in the most efficient manner.

Work Incentive Planning and Assistance (WIPA) and Protection and Advocacy for Beneficiaries of Social Security (PABSS) Programs

4. What are SSA's plans for further evaluation of the WIPA program?

Our contractor, Mathematica Policy Research (MPR), will match administrative data on WIPA program users with other agency administrative data. MPR will analyze the number and characteristics of WIPA users, the types of WIPA services these users receive, beneficiary utilization of our work incentive provisions, beneficiary employment and earnings, and termination of disability benefits due to work. MPR will compare the characteristics and employment outcomes of WIPA users to those of

a comparable sample of beneficiaries who do not use the WIPA program and will assess how WIPA users differ from other beneficiaries.

In addition, we will conduct a national survey measuring customer satisfaction with the WIPA program in Fall 2009.

5. **Does SSA have plans to evaluate the PABSS program? What data is the agency currently collecting on PABSS program participants, services provided, and outcomes?**

We already evaluate the PABSS program. Through our technical assistance contractor, the National Disability Rights Network (NDRN), we collect State-level data on the number and characteristics of PABSS program participants, their concerns, the services provided, and the results of the provided services. We use these data to evaluate the effectiveness of these programs and make necessary changes.

6. **Please provide the following information for each of fiscal years 2004 through 2008, and for the first six months of FY 2009:**

   a. **How many beneficiaries used the WIPA program?**

The BPAO Program: FY 2004 – 2006

The Virginia Commonwealth University (VCU) database contains information on the original Benefits Planning, Assistance and Outreach (BPAO) Program from FY 2004 through FY 2006. The VCU database shows the following number of beneficiaries served by the BPAO projects during these timeframes:

FY 2004 – 56,925
FY 2005 – 56,497
FY 2006 – 45,520

The WIPA Program: 2007 – Present

2007 – 30,410
2008 – 43,790
2009 (as of 6/23/09) – 16,430

The data provided for 2007 and 2008 numbers are not complete.

The numbers represent people who received information, referral services, or WIPA core services (e.g., verifying Social Security benefits, verifying health insurance, and obtaining subsidized housing). The database does not track the type of WIPA assistance beneficiaries received.

b. How many beneficiaries used the PABSS program?

The first reliable data are from 2004. In 2006, the NDRN developed an online database for all PABSS projects. Unfortunately, not all of the data were saved to this database.

Information and Referral Services

When they provide information and referral services, protection and advocacy (P&A) groups do more than simply give beneficiaries numbers to call. P&A groups provide accurate information that empowers individuals to become their own advocates. Information and referral requests may involve many issues per each individual beneficiary. A breakdown of the number of beneficiaries served in each fiscal year is as follows:

FY 2006	9,517
FY 2007	9,737
FY 2008	6,562

Service Requests

If a beneficiary needs additional services, the P&A group opens a "service request." Service requests include a more in-depth intervention, such as providing counseling and legal assistance. During the period FY 2004 through FY 2008, 14,428 beneficiaries received this type of service. A breakout of services provided to beneficiaries by fiscal year is as follows:

FY 2004 & 2005	7,358
FY 2006	2,174
FY 2007	2,435
FY 2008	2,461

Work CDRs and Overpayments

7. What is SSA's plan for reducing the backlog of work CDRs and speeding up processing of reports of earnings by DI beneficiaries? Will the agency be using any of the dedicated program integrity funds provided under the FY 2009 appropriation and the President's proposed 2010 budget for this purpose?

We plan to maintain our historic level of 170,000 work CDRs in FY 2009 and FY 2010. The agency will use some of the dedicated program integrity funds provided under the FY 2009 appropriation and the FY 2010 budget for work CDRs.

8. Do you have an estimate of the ratio of program savings to administrative costs for conducting work CDRs?

We do not have an estimate for the ratio of program savings to administrative costs for conducting work CDRs. The agency does not track this data.

9. In May 2008, SSA staff briefed Subcommittee staff on work CDRs, and indicated that the agency was in the process of developing performance measures for this workload. Have these been developed? If so, what are the measures? If not, when will they be completed? Given the importance of timely processing of work CDRs, will SSA begin including performance targets for this workload in the Annual Performance Plan and Performance and Accountability Report?

In the briefing mentioned above, our staff was referring to improving and standardizing the available management information for work CDRs, which we believe will help improve the processing of work CDRs, as well as performance. This effort is independent of the consideration of any performance measures or targets for work CDR processing. We do not have national work CDR targets or goals and do not have any immediate plans to set them.

10. The Subcommittee has received numerous reports that DI beneficiaries who properly report their earnings still frequently receive large overpayments. In her testimony for this hearing, Ms. Bates-Harris provided an account of a beneficiary who was overpaid almost $64,000 despite reporting his earnings. To allow us to better understand the size the overpayment problem, please provide the information below for DI beneficiaries whose benefits were ceased due to work and who received notice of the cessation in the period from the beginning of FY 2007 to the present (broken down by the fiscal year in which, the notice was sent):

a. The number of beneficiaries whose benefits were ceased due to work.

This information is not readily available by fiscal year. In calendar year 2007, we ceased the benefits of 37,640 beneficiaries due to work activity. We cannot yet determine the comparable numbers for calendar years 2008 and 2009.

b. For those whose benefits were ceased due to work, the average amount of DI benefits overpaid.

Based on an informal study done in 2007, disability cessation overpayments attributed to work activity in 2004 through 2006 averaged about $11,000 to $12,000.

c. For those whose benefits were ceased due to work, the number and percentage of beneficiaries with overpayments of:

i. -$4999 or less

ii. -$5000-9,999

iii. -$10,000 -19,999
-$20,000 -29,999
-$30,000 or more

We do not have this information.

d. The total amount overpaid for this population

We do not have specific data to answer this question conclusively. We estimate that about 80 to 85 percent of overpayment dollars identified in FY 2008 as a result of a disability cessation can be attributed to work activity. This would equal about $600 to $700 million.

e. The total amount of these overpaid funds that have been recovered to date

We do not have information about the percentage of overpayments that are actually recovered. However, in tracking overpayments over a period of time, we found that 50 percent of the disability cessation debt had been recovered after a period of ten years. We do not have data on the total value of these recoveries.

11. Ms. Suter's written testimony stated: "...we are collaborating with all stakeholders to develop proposals to ensure that beneficiaries who report their earnings timely will not be penalized for our delays in processing their work CDRs." Can you tell us more about these proposals? When do you expect the specific proposals to be available?

As Ms. Suter testified, we want to simplify our work incentives for disability beneficiaries to reduce the likelihood of overpayments. Since we are in the earliest stages of formulating proposals to address this issue, it would be premature to discuss any specific options under consideration. We would be happy to work with Congress to develop proposals aimed at reducing these overpayments.

In some cases, our current policy allows people to keep overpayments. We can waive recovery of an overpayment if both of the following conditions are met: the person is without fault in causing the overpayment and recovery of the overpayment would either defeat the purpose of the Social Security Act or be against equity and good conscience.

Work Incentives Policy

12. Ms. Suter testified that SSA is working on proposals for simplifying the work incentives. When can the Subcommittee expect to see these proposals?

At this time, we are considering a variety of options to simplify work incentives, but we do not have a final proposal. We are exploring possible changes related to the trial work period, work CDRs, and the extended period of eligibility. As soon as we have a final proposal, we will share it with the Subcommittee.

Questions from Representative Ron Kind

1. **Ms. Suter's testimony mentioned that SSA wants "to test other disability program modifications and have several new ideas for demonstration projects." What ideas and projects are being considered? The testimony also mentions that SSA would develop a detailed plan if SSDI demonstration authority is reinstated. How would SSA develop such a plan?**

Our authority to initiate new demonstration projects under Section 234 of the Social Security Act expired on December 18, 2005. Demonstration projects that we initiated before that date can continue. We have begun to identify some ideas for new demonstration projects that address issues raised by our stakeholders, such as the Congress and advocates. If the Congress renews this demonstration authority, we will continue to develop potential projects.

We would like to explore further a program described by the Social Security Advisory Board (SSAB) in their September 2006 report titled, "A Disability System for the 21st Century." The SSAB discusses an early intervention program in which we provide SSDI applicants with information and resources they may use to continue working. This early intervention program recognizes that the underlying "all or nothing" concept of the SSDI program may discourage some SSDI applicants from working to their potential. In the early intervention demonstration project, we would test whether providing resources to people with disabilities before they undergo our disability determination process assists those people in maintaining a connection to the workforce, and reduces their need for the SSDI program.

The SSAB report provides a blueprint for our planning efforts on this project, but we will need to develop the implementation details. We will begin our planning by forming a panel of researchers and practitioners who are rehabilitation experts. The panel will prepare a report that will describe the details of the project, such as the method for identifying participants, and the resources and information those participants may receive. When we complete the plan, we will consider hiring a firm to conduct the demonstration, and another firm to evaluate the demonstration.

We are developing another project in collaboration with the Administration for Children and Families (ACF) within the Department of Health and Human Services

that we call the Temporary Assistance for Needy Families (TANF)/SSI Disability Transition Project. In this project, we will examine the overlap in the TANF and SSI populations, document current approaches for identifying and working with people with disabilities, and identify approaches to work more effectively and efficiently with individuals who may be eligible for SSI. Initially, we are developing data sharing agreements with six States. We will use data from those six States to measure the number of TANF applicants and recipients who have applied for SSI and the outcomes of those applications. ACF and SSA are jointly funding a contractor that will develop and pilot promising approaches to screening and encouraging work activities. We will use the results of the pilots to determine whether a larger demonstration project is warranted.

We are currently focusing on the link between TANF and SSI as there is known overlap in the two programs. We would also like to study the link between TANF applicants and SSDI beneficiaries and concurrent beneficiaries. Section 1110 of the Act provides us with authority to waive SSI rules to implement this project. We will need Section 234 authority to waive SSDI rules so we can include SSDI or concurrent beneficiaries in the demonstration project. Although we have not identified the interventions that we would test, we are considering excluding TANF employment activities in our eligibility determinations or providing protective filing status for potential claimants who defer the disability application process to pursue employment through participation in TANF-sponsored work activities.

If the Congress renews our demonstration authority, we will further examine the feasibility of these projects. As we move forward with developing the projects, we will share our plans with our key stakeholders, including the Congress, the SSAB, and the disability advocacy community.

2. In her oral testimony, Ms. Suter mentioned that the disability programs should be simplified and harmonized. Could you say more about this?

Improving the consistency of policy across programs would make it easier for beneficiaries to understand program rules and, potentially, more efficient for us to administer the programs. There are a variety of examples in which similar policies are administered differently across our program. The SSDI and SSI programs use separate rules to determine cash benefits for blind and disabled beneficiaries who work. Under the SSI program, when a beneficiary works we reduce cash benefits as a result of the earnings. We withhold $1 in cash benefits for every $2 in countable earned income that exceeds $65 in a month. Under the SSDI program, we evaluate work activity to determine if a beneficiary has done substantial work. When an SSDI beneficiary does substantial work, we determine his or her disability has ceased and we withhold the beneficiary's entire cash benefit for months of Substantial Gainful Activity (SGA). These differences can confuse our beneficiaries.

Furthermore, we offer work incentives, such as the trial work period and the extended period of eligibility, that allow SSDI beneficiaries to work without permanently

losing their cash benefits. There are other work incentives that may allow beneficiaries to continue receiving their Medicare benefits after their cash benefits end. These work incentives have good purposes; however, their complexity make them difficult for beneficiaries to understand, and difficult for us to administer.

In the SSDI program we must determine if a beneficiary is doing SGA to determine if disability ceases, and we normally use the beneficiary's monthly earnings to place the value on the work activity in that month. Under the SSI program, we normally count the earned income in the month the earnings are actually paid. Beneficiaries, especially those beneficiaries who receive both SSI and SSDI benefits, can become confused over these different earnings treatments.

We are in the process of implementing a $1 for $2 offset demonstration project that will test the effect of replacing our current SSDI SGA system with an offset system similar to the system we use in the SSI program. In the meantime, we are looking to make our programs easier to understand and administer by simplifying our SSDI work rules and more closely synchronizing our SSDI policies and procedures with our SSI policies and procedures.

3. How does SSA plan to evaluate the new Ticket regulation issued in May 2008?

Please see the response to question 3 from Chairman Tanner.

Questions from Representative Danny K. Davis

1. Given the seriousness of the problem of overpayments, what steps is Social Security taking to solve this problem?

We use several different processes and software components to obtain work information and process reports of work and earnings.

The Social Security Protection Act requires that we provide work report receipts to disability beneficiaries. We use the eWork system to generate those work report receipts, as well as to control Title II work reports until we take final action on them. The eWork software helps us in the intake, development, processing, and control of work issues from the initial report of work activity to final processing. eWork is a nationally accessible, web-based system that replaces our prior system and provides expanded functionality.

The Disability Control File (DCF) houses data regarding work activity and other disability-related information. We use the DCF to store information on work activity for disability beneficiaries and to control certain processing actions. We also use the DCF in conjunction with our CDR Enforcement Operation (CDREO) to help identify when a disability beneficiary has wages or self-employment income reported in the Master Earnings File, but we have not yet conducted a review of that work activity. We control CDREO alerted cases with the DCF until we take final action.

We query the Office of Child Support Enforcement's new hire database for both Title II and Title XVI disability applicants and beneficiaries via online access, and we have a batch operation for Title XVI. The new hire database allows us to identify unreported work activity more quickly because we access it quarterly. We are studying the effectiveness of using a batch operation for Title II that will work similarly to the CDREO system.

The SSI Automated Telephone Wage Reporting System (SSITWR) makes it easier to report monthly wages. Using SSITWR, the public can report wages without having to mail pay slips or contact a field office directly. This new system is available nationwide. We require our employees to inform beneficiaries of the SSITWR during post-eligibility, wage-related contacts, pre-effectuation reviews, and redeterminations. We considered using a centralized unit to process work CDRs for Ticket participants when the Ticket program began. However, because we consider all work CDRs equally important, we determined we would need a very large centralized unit to cover work CDRs nationwide. In addition, local offices can often work with local employers to obtain needed information and are in a better position to obtain other detailed information from an employer than a large, out-of-area centralized unit.

2. **Work incentives and rules for determining countable income are not well understood by the beneficiaries or those that work with them. The WIPA Projects, while helpful, cannot be the only avenue for getting any information. What initiatives are you planning to make sure this information about work incentives saturates our communities and SSA offices?**

Our Ticket to Work Program Manager for Recruitment and Outreach (PMRO), the Cherry Engineering Support Services, Inc. (CESSI) division of Axiom, has worked aggressively to expand awareness regarding work incentives and income rules.

For example, the PMRO and our staff members participate in disability-related conferences around the Nation in order to improve educational awareness regarding the Ticket to Work Program and work incentives. Conference participation can include conducting workshops, making a presentation, or setting up an informational exhibit. Many of these events reach service providers who are the key link in forwarding appropriate information to beneficiaries regarding their options and countable income rules. In 2008, the PMRO participated in 109 events that reached 23,894 individuals. Through mid-June 2009, the PMRO participated in 86 events that reached 22,215 people. For the rest of the year, the PMRO plans to participate in another 50 educational and outreach events.

Working in partnership with our Office of Employment Support Programs, the PMRO has also initiated new beneficiary outreach programs. This effort targets specific communities to improve program awareness and assist individuals in advising beneficiaries regarding program requirements.

Our field offices stock several publications related to work incentives. For example, we routinely distribute a pamphlet called, "Working While Disabled - How We Can Help," which provides information on work incentives. Field offices also distribute publications related to the Ticket program.

3. **I see educational outreach related to WIPA as in line with the requirement to create a larger education and outreach system for service providers and beneficiaries under Section 121 Outreach, Section 122 State Grants of the Ticket to Work Act. What has the Social Security Administration done to implement this section and why is it not working?**

   Sections 121 and 122 of the Ticket to Work Act established the WIPA and PABSS programs. Pursuant to this mandate, we started awarding cooperative agreements under the WIPA program in fiscal year 2000 and grants under the PABSS program in fiscal year 2001.

   Both of these programs have vigorously pursued education and outreach activities. For example, our WIPA projects held 111 Work Incentives Seminar events in 2008. These events are designed to provide those receiving SSI or SSDI benefits with knowledge necessary to either assign their Ticket or pursue other work incentives. These events provide beneficiaries with information on different choices available to help them go to work for the first time, return to work, or reach other employment goals.

   As described in our replies to Chairman Tanner's questions, both of these programs provide valuable assistance to beneficiaries who are exploring their options to return to work and reduce their dependence on cash benefits. Furthermore, we are evaluating the effectiveness of both programs and will make any necessary changes.

4. **Another area of opportunity for beneficiary education and outreach – again, in addition to the WIPA services – is providing critical information at the point of application for disability programs. Does SSA analyze when is the best time or the right time to send the Ticket to Work to disability beneficiaries? Could SSA separate the "quick" awards from those who go through the appeals process – and should they be treating these folks differently? If not, why not?**

   We have consistently found that the interest in employment services is strongly correlated with time on the disability rolls. As MPR noted in its May 2007 Ticket program evaluation report, beneficiaries on the rolls for more than one year, but less than five years, are most likely to report having work goals and expectations. This finding suggests that the timing of follow-up promotions for the Ticket program and work incentives should occur about one year after beneficiaries have come on the rolls and continue until about five years after that point.

   We have also found that those beneficiaries who received their benefit allowance only after appealing an initial denial beyond the reconsideration level were less likely

to participate in the Ticket program than those who received their allowance at the initial determination level.

We send Tickets to all disability beneficiaries who are at least 18 years old immediately after we send their award notices. However, the Act restricts the Ticket program to disability beneficiaries. Therefore, we could not issue a Ticket to an applicant whom we were likely to quickly allow before we approved his or her disability claim.

5. **What kind of information do SSA beneficiaries get on the SSA work incentives prior to getting the Ticket to Work? Does SSA introduce applicants and beneficiaries to the employment support programs and work incentives (all of them, not just the ticket) before sending the Ticket?**
We instruct our interviewers to introduce applicants to all our employment support programs and work incentives, including rehabilitation services, the Ticket Program, and other work incentives (such as the trial work period). The interviewer also gives the applicant a booklet identifying additional sources of information about our work incentives ("Disability Benefits"). All disability beneficiaries who are at least 18 years old receive their Tickets immediately after they receive their award notices.

   We recognize the importance of promoting work incentives to help disability beneficiaries return to work, and provide them numerous opportunities to learn about work incentives. For example, our *Red Book*, which we publish annually, is a work incentives guide for disability beneficiaries. A disability beneficiary who is considering working may request a Benefits Planning Query (BPQY) for planning purposes. The BPQY provides information about a beneficiary's disability benefits and work history. Finally, when a beneficiary has started working, we send a booklet on work incentives ("Working While Disabled - How We Can Help").

6. **Under the Ticket to Work in the Partnership Plus Model, what kind of payments are partners getting (in dollars, not percentages)?**

   As of May 31, 2009, we had paid approximately $275,000 to ENs that are providing job retention supports after VR case closure.

7. **How many individuals using their Ticket to Work are working in jobs earning wages beyond Substantial Gainful Activity ($1640 monthly for statutorily blind individuals; $980/month for the non-blind individuals)?**

   As of May 31, 2009, there were 2,299 Ticket users who were earning wages beyond SGA.

8. **What data does SSA have on individuals who are using the Ticket to Work successfully?**

   The fourth Ticket program evaluation report provides extensive information about the

share of Ticket program participants who were employed and their job characteristics. Our findings in the fourth report indicate the following:

- Ticket program participants are more than three times as likely as other beneficiaries to have engaged in recent employment-related activities: 68 percent of Ticket program participants were either working at interview, looking for work at interview, or had worked during the previous year compared to just 18 percent of all beneficiaries.

- The Ticket program participant employment rate is nearly four times that of all beneficiaries (34 percent compared with 9 percent).

- Among those beneficiaries who were employed, Ticket program participants worked a similar number of hours relative to others, but earned higher wages on average ($8.00 per hour versus $6.40), were more likely to work above the substantial gainful activity level (32 percent versus 25 percent), and were more likely to be in competitive (rather than sheltered) employment (64 percent versus 58 percent).

- There were significant differences in the employment outcomes of Ticket program participants assigned to ENs and SVRAs. Those assigned to ENs and SVRAs were equally likely to be employed, but working participants assigned to ENs worked more hours, had higher wages and earnings, were offered more job-related benefits, and were less likely to be in sheltered employment relative to working participants assigned to SVRAs.

In the fourth report we assessed the extent to which Ticket program participants generated outcome payments and left the disability rolls due to work as of December 2005. Our findings indicate that 12 percent of an early cohort of Ticket program participants (those who assigned their Tickets in early 2002) had left the rolls for at least one month due to work by December 2005. Our forthcoming fifth Ticket program evaluation report paper will analyze the share of early Ticket program participants who left the disability rolls for at least one month due to work as of December 2007; preliminary analysis finds that 19 percent did so.

Our fourth Ticket program evaluation report also contains statistics on the extent to which Ticket program participants earned enough to generate outcome payments. These statistics are only for beneficiaries in Phase 1 States for the years 2002 through 2004 and reflect both payment processing times and the time needed to develop and process the data. The statistics show, for instance, that in 2004, early (Phase 1) participants spent the equivalent of 335 years off the disability rolls because of work. The report presents additional statistics on months off the rolls because of work, including statistics for those who enrolled for services with an SVRA under the traditional payment system.

SOCIAL SECURITY

The Commissioner

July 24, 2009

The Honorable Sam Johnson
Ranking Member, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Johnson:

Thank you for your June 2, 2009, letter requesting additional information to complete the record for the May 19, 2009, hearing on our employment support programs for disability beneficiaries. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Angela Arnett, our Acting Deputy Commissioner for Legislative and Regulatory Affairs, at (202) 358-6030.

Sincerely,

/s/

Michael J. Astrue

Enclosure

Questions for the Record
For the May 19, 2009, Hearing
On the Social Security Administration's (SSA)
Employment Support Programs for Disability Beneficiaries
Questions from Representative Sam Johnson

Program Statistics

1. **Please provide the following information for Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) work incentive programs administered by SSA, by specific work incentive annually since 2002:**

   - **How many individuals participating,**
   - **How many SSA staff are involved administering the incentive,**
   - **Estimated costs to SSA of administering each incentive,**
   - **Average annual earnings of incentive participants, and**
   - **The number of participants who worked their way off of benefits.**

   Bullet 1: How many individuals participating?

   We also provide where available the average annual earnings of incentive participants in reply to Bullet 4.

   - Trial Work Period (SSDI only) - The participation rate and average annual earnings of SSDI beneficiaries who are still in their trial work period (have not completed the 9th month) are:

Calendar Year	Number of Beneficiaries	Average Annual Earnings
2008*	80,700	$12,600
2007*	144,000	$10,900
2006*	185,500	$10,600
2005	206,300	$9,600
2004	193,000	$9,400
2003	170,800	$9,200
2002	155,300	$9,200

Source: Disability Control File
* Calendar years 2006 to 2008 are not final. These years are subject to change as work reviews are completed.

- Extended Period of Eligibility (SSDI only) - The participation rate and average annual earnings of SSDI beneficiaries who have completed their 9th month of the trial work period and are in the extended period of eligibility are:

Calendar Year	Number of Beneficiaries	Average Annual Earnings
2008*	63,300	$23,300
2007*	100,100	$21,600
2006*	120,100	$20,000
2005	127,400	$20,200
2004	118,000	$19,300
2003	107,500	$18,100
2002	85,700	$17,000

Source: Disability Control File

* Calendar years 2006 to 2008 are not final. These years are subject to change as work reviews are completed.

- Subsidies and Special Conditions (SSDI only) - We do not maintain annual participation rates or average annual earnings. However, in February 2008, we conducted a special study that showed 8,461 people participated in calendar year 2007.

- Extended Medicare After Work Cessation (SSDI only) (Average annual earnings are not available.)

Calendar Year	Number of Ceased Beneficiaries
2008	87,000
2007	84,100
2006	83,600
2005	82,100
2004	75,800
2003	65,000
2002	Unavailable

Source: Master Beneficiary Record (100 percent extract from December of each year)

- Continued Payments While Participating in a Vocational Rehabilitation (VR) Program - We do not have either SSDI or SSI annual participation rates or average annual earnings. However, we have a static count from 2007 and a 2009 participation estimate based on the first three months of 2009.

    - In 2007, we continued the benefits of over 400 beneficiaries after a medical cessation.
    - In 2009, we estimate that we will continue the benefits of over

1,500 beneficiaries. We expect this increase because we now include students aged 18-21.

- Impairment Related Work Expenses
  - SSDI (Average annual earnings are not available.)

Calendar Year	Number of Beneficiaries
2008	4,800
2007	4,200
2006	4,600
2005	4,100
2004	3,300
2003	2,200
2002	1,400

Source: Disability Control File.

  - SSI

Calendar Year	Number of Beneficiaries	Average Annual Earnings
2008	4,572	Unavailable*
2007	5,160	$7,068
2006	5,650	$6,612
2005	6,310	$6,312
2004	6,870	$6,144
2003	7,600	$6,252
2002	8,040	$6,288

Source: SSA Supplemental Security Record (Characteristic Extract Record Format)
*We do not consider the previous year's earnings data for a beneficiary complete until we have completed the Master Earnings File match with the Internal Revenue Service (IRS). This can take up to 12 months after the end of the year.

- Expedited Reinstatement (SSDI and SSI per year) (Average annual earnings are not available.)

Fiscal Year	Number of Beneficiaries Reinstated
2008	12,499
2007	10,932
2006	9,790
2005	7,909
2004	6,373
2003	6,076
2002	Unavailable

Source: National Disability Determination Services (DDS) System – DDS Database

- Blind Work Expenses (SSI only). This chart includes the number using this provision and their average annual earnings.

Calendar Year	Number of Beneficiaries	Average Annual Earnings
2008	1,925	Unavailable*
2007	2,140	$13,020
2006	2,370	$12,336
2005	2,550	$11,628
2004	2,820	$11,028
2003	3,070	$11,340
2002	3,380	$11,616

Source: SSA Supplemental Security Record (Characteristic Extract Record Format)
*We do not consider the previous year's earnings data for a beneficiary complete until we have completed the Master Earnings File match with IRS. This can take up to 12 months after the end of the year.

- Student Earned Income (SSI only) (Average annual earnings are not available.)

Calendar Year	Number of Beneficiaries
2005	25,650
2004	26,050

Annual participation rates for other years are not available.

- Plan to Achieve Self-Support (SSI only). This chart includes the number using this provision and their average annual earnings.

Calendar Year	Number of Beneficiaries	Average Annual Earnings
2008	1,559	Unavailable*
2007	1,510	$9,732
2006	1,580	$9,504
2005	1,580	$10,080
2004	1,600	$9,060
2003	1,700	$8,640
2002	1,720	$8,700

Source: SSA Supplemental Security Record (Characteristic Extract Record Format)
*We do not consider the previous year's earnings data for a beneficiary complete until we have completed the Master Earnings File match with IRS. This can take up to 12 months after the end of the year.

- Continued Payments for Working SSI Beneficiaries – 1619(a). This chart includes the number using this provision and their average annual earnings.

Calendar Year	Number of Beneficiaries	Average Annual Earnings
2008	16,142	Unavailable*
2007	16,930	$14,316
2006	17,390	$13,992
2005	17,620	$13,332
2004	17,110	$12,912
2003	17,130	$12,708
2002	17,270	$12,516

Source: SSA Supplemental Security Record (Characteristic Extract Record Format)
*We do not consider the previous year's earnings data for a beneficiary complete until we have completed the Master Earnings File match with IRS. This can take up to 12 months after the end of the year.

- Medicaid for Working SSI Beneficiaries – 1619(b). This chart shows the number using this provision and their average annual earnings.

Calendar Year	Number of Beneficiaries	Average Annual Earnings
2008	99,482	Unavailable*
2007	97,550	$15,204
2006	89,350	$14,304
2005	78,200	$13,416
2004	73,680	$12,840
2003	71,090	$12,972
2002	82,170	$13,128

Source: SSA Supplemental Security Record (Characteristic Extract Record Format)
*We do not consider the previous year's earnings data for a beneficiary complete until we have completed the Master Earnings File match with IRS. This can take up to 12 months after the end of the year.

Below is the combined average annual earnings of all SSI beneficiaries, aged 18 to 64, using the following work incentives: impairment related work expenses, blind work expenses, plans to achieve self support, 1619(a), and 1619(b). (Does not include student earned income exclusion.)

Calendar Year	Number of Beneficiaries	Combined Average Annual Earnings
2008	123,680	Unavailable*
2007	123,290	$11,868
2006	116,340	$11,350
2005	106,260	$10,954
2004	102,080	$10,397
2003	100,590	$10,382
2002	112,580	$10,450

Source: SSA Supplemental Security Record (Characteristic Extract Record Format)
*We do not consider the previous year's earnings data for a beneficiary complete until we have completed the Master Earnings File match with IRS. This can take up to 12 months after the end of the year.

Bullet 2: How many SSA staff are involved administering the initiative?

Approximately 1,365 of our employees are involved in administering the work incentive provisions:

- 1,259 Work Incentive Liaisons (one in each field office);
- 54 Area Work Incentives Coordinators;
- 34 Plan to Achieve Self-Support Specialists;
- 10 Ticket to Work (TTW) Coordinators;

- 6 Policy Analysts in Headquarters; and
- 2 Program Analysts in Headquarters.

Generally, the employees who help administer the work incentives provisions handle all the incentives. However, the 34 Plan to Achieve Self-Support (PASS) Specialists concentrate on the PASS. The 10 TTW Coordinators concentrate on the Ticket program, and the 2 program analysts concentrate on the Ticket program.

Bullet 3: Estimated costs to SSA of administering each incentive.

We are unable to break out the costs of administering each work incentive because these provisions are interrelated. The work incentive liaisons spend approximately 10 percent of their time on work incentive activities. Four policy analysts spend 100 percent of their time on administering work incentive provisions. Two additional policy analysts and two program analysts spend about 20 percent of their time on the initiative. The area work incentives coordinators and plan to achieve self-support specialists generally spend 90 percent and the TTW coordinators spend about 75 percent of their time on these activities. We estimate the average annual administrative costs based on salaries at $14 million.

We fund the Work Incentives Planning and Assistance (WIPA) program to provide services to beneficiaries on work incentives, benefits planning and assistance, and job placement and career development. The cost is $23 million annually, including cooperative agreements to 104 WIPA projects across the Nation and U.S. territories and a Training and Technical Assistance Contract with Virginia Commonwealth University.

Bullet 4: Average annual earnings of incentive participants.

Please see our response to Bullet 1.

Bullet 5: The number of beneficiaries who worked their way off benefits using work incentives.

- Number of SSDI beneficiaries whose benefits ceased due to successful work.

Calendar Year	Number Ceased
2008	Unavailable*
2007	37,460
2006	36,242
2005	36,363
2004	26,613
2003	27,928
2002	29,165

Source: Disability Control File

We cannot identify which particular provisions SSDI beneficiaries used to work their way off the rolls because a beneficiary may use a combination of work incentives at different times. However, all SSDI beneficiaries who have successfully returned to work have generally used the trial work period and the extended period of eligibility before being ceased for work.

- We cannot identify which particular provisions SSI beneficiaries may have used to work their way off the rolls because a beneficiary may use a combination of work incentives at different times. One provision we can specifically identify is ongoing Medicaid eligibility for certain SSI beneficiaries who lose eligibility to cash benefits due to work. The following chart provides those numbers.

  Medicaid for Working SSI Beneficiaries – 1619(b)

Calendar Year	Number Using Provision	Average Annual Earnings
2008	99,482	Unavailable*
2007	97,550	$15,204
2006	89,350	$14,304
2005	78,200	$13,416
2004	73,680	$12,840
2003	71,090	$12,972
2002	82,170	$13,128

Source: SSA Supplemental Security Record (Characteristic Extract Record Format)
*We do not consider the previous year's earnings data for a beneficiary complete until we have completed the Master Earnings File match with IRS. This can take up to 12 months after the end of the year.

- We do not have the number whose SSI benefits we terminated for successful work. However, in 2008, for SSI beneficiaries aged 18 to 64:
  - We terminated over 250,000 due to excess income (includes earnings),
  - We terminated over 25,000 due to medical improvement (includes successful return to work).

2. **What are the most common reasons people leave the SSI program, in order of most common to least common. For example, how does "earnings from work" compare with death, imprisonment, and leaving the country as a reason why people leave the SSI rolls? How many disabled workers have left the SSI rolls permanently after participating in one of the work incentive programs?**

   The table below provides the termination reasons and termination length for SSI beneficiaries aged 18 to 64.

SSI Beneficiaries, Age 18-64, Who Terminated in 1980-2008, Reason and Length of Time Since Termination Without Re-Entitlement

Reason for Termination	Terminated 0 to 5 yrs	Terminated 6 to 10 yrs	Terminated 11 to 15 yrs	Terminated 16 or more yrs
Excess income*	56.5%	50.5%	52.7%	50.3%
Death	23.4%	24.0%	26.0%	25.9%
In public institution	5.8%	6.0%	5.6%	4.4%
Medical improvement	5.9%	8.6%	6.8%	2.8%
Excess resources	2.9%	3.2%	2.9%	4.2%
Failure to furnish report	1.1%	2.3%	0.8%	3.2%
Whereabouts unknown	1.0%	1.8%	1.7%	1.2%
Outside United States	0.7%	0.6%	0.8%	0.7%
Other	2.9%	2.8%	2.8%	7.3%

Source: SSA Supplemental Security Record (Characteristic Extract Record format), 100 percent data

* includes both earned and unearned income

We do not maintain the specific data necessary for determining the number of SSI disability beneficiaries who permanently left the rolls after participating in one of the work incentive programs. The percentages above do not include SSI beneficiaries who are in 1619(b) status because they are not terminated (despite not receiving cash benefits).

3. Please provide the following information annually for years beginning in 2002 and cumulatively.

Tickets

- **# Tickets issued to beneficiaries**
- **# Tickets assigned by all eligible beneficiaries**
- **# Tickets assigned to ENs**
- **# Tickets assigned to VRs acting as ENs**

ENs

- **# ENs under contract (i.e. EN awards)**
- **# ENs with Tickets assigned**
- **# ENs received payment**

EN Payments

- **# outcome and milestone payments made to ENs**
- **$ outcome and milestone payments made to ENs**

Beneficiaries

- **#Ticket beneficiaries whose earnings generated payments to ENs**
- **# Ticket beneficiaries who have had benefits suspended and/or left the rolls due to work and earnings**
- **# months for which benefits were not paid due to work and earnings**

Program costs/savings

- **Program savings**
- **Program administrative costs (including staff support/contracts, etc.)**

Please note that the yearly totals shown in several of the tables below do not add up to the cumulative total. For example, an individual Employment Network (EN) may show up in several different years, while the cumulative only counts them once to avoid inflating the total number of ENs involved in the program.

Tickets

- # Tickets issued to beneficiaries

FY 2002	2,454,238	
FY 2003	3,199,127	
FY 2004	4,318,334	
FY 2005	1,082,358	
FY 2006	974,460	
FY 2007	955,821	
FY 2008	1,237,168	
FY 2009 (through 05/31/09)	1,169,023	Est. for FY 2009 = 1,753,535
Cumulative issued	15,390,529 *	

Source: Disability Control File/Comprehensive Work Opportunity Support System (DCF/CWOSS)
* There are 11,282,087 active tickets as of May 31, 2009. Tickets terminate due to beneficiaries attaining age 65 and other reasons.

- # Tickets assigned by all eligible beneficiaries

	# Assigned in FY	Total Assigned
FY 2002	7,799	7,799
FY 2003	18,812	26,611
FY 2004	39,089	65,700
FY 2005	40,267	105,967
FY 2006	41,476	147,443
FY 2007	35,509	182,952
FY 2008	30,764	213,716
FY 2009 (through 05/31/09)	56,016	269,732

Source: MAXSTAR –database of MAXIMUS, SSA's Operations Support Manager

- # Tickets assigned to ENs

FY 2002	1,634	
FY 2003	2,747	
FY 2004	4,245	
FY 2005	3,530	
FY 2006	3,393	
FY 2007	3,214	
FY 2008	7,070	
FY 2009 (through 05/31/09)	7,257	Est. for FY 2009 = 10,886
Current total as of 05/31/09*	22,864	

Source: Disability Control File/Comprehensive Work Opportunity Support System (DCS/CWOSS)
* Figures do not add up, as we take tickets out of assignment or terminate them over time.

- # Tickets assigned to VRs acting as ENs

FY 2002	474	
FY 2003	1,611	
FY 2004	2,842	
FY 2005	1,897	
FY 2006	1,408	
FY 2007	1,011	
FY 2008	1,084	
FY 2009 (through 05/31/09)	1,739	Est. for FY 2009 = 2,609
Current total as of 05/31/09*	10,756	

Source: Disability Control File/Comprehensive Work Opportunity Support System (DCF/CWOSS)
* Figures do not add up, as we take tickets out of assignment or terminate them over time.

ENs

- # ENs under contract (i.e., EN awards)

	New Awards	EN Contracts as of 09/30
FY 2002	448*	448
FY 2003	447	878
FY 2004	407	1,147
FY 2005	265	1,365
FY 2006	67	1,339
FY 2007	42	1,245
FY 2008	203	1,173
FY 2009 (current through 05/31/09)	288	1,294

Source: MAXSTAR –database of MAXIMUS, SSA's Operations Support Manager
* 1st year includes some contracts that we awarded prior to the rollout of the program.

- # ENs with Tickets assigned*

FY 2002	120
FY 2003	296
FY 2004	520
FY 2005	623
FY 2006	659
FY 2007	661
FY 2008	644
FY 2009 (Current as of 05/31/09)	827

Source: MAXSTAR –database of MAXIMUS, SSA's Operations Support Manager

* The number of ENs with at least one ticket assigned at any time during the fiscal year.

- # ENs received payment*

FY 2002	6	
FY 2003	79	
FY 2004	162	
FY 2005	235	
FY 2006	238	
FY 2007	203	
FY 2008	205	
FY 2009 (through 05/31/09)	295	Est. for FY 2009 = 443
Cumulative **	526	

Source: Disability Control File/Comprehensive Work Opportunity Support System (DCF/CWOSS)

* The number of ENs with at least one payment in the fiscal year.

** Figures do not add up, as an EN paid in multiple years is only counted once in the cumulative total.

EN Payments

- # outcome and milestone payments made to ENs

FY 2002	15	
FY 2003	910	
FY 2004	2,553	
FY 2005	6,397	
FY 2006	9,191	
FY 2007	10,923	
FY 2008	15,705	
FY 2009 (through 05/31/09)	14,453	Est. for FY 2009 = 21,680
Cumulative	60,147	

Source: Disability Control File/Comprehensive Work Opportunity Support System (DCF/CWOSS)

- $ Outcome and milestone payments made to ENs

FY 2002	$4,462	
FY 2003	$280,906	
FY 2004	$839,334	
FY 2005	$2,229,321	
FY 2006	$3,047,249	
FY 2007	$3,764,190	
FY 2008	$5,884,005	
FY 2009 (through 05/31/09)	$7,792,736	Est. for FY 2009 = $11,690,000
Cumulative	$23,842,203	

Source: Disability Control File/Comprehensive Work Opportunity Support System (DCF/CWOSS)

Beneficiaries

- # Ticket beneficiaries whose earnings generated payments to ENs*

FY 2002	9	
FY 2003	272	
FY 2004	583	
FY 2005	1,182	
FY 2006	1,469	
FY 2007	1,708	
FY 2008	2,478	
FY 2009 (through 05/31/09)	3,436	Est. for FY 2009 = 5,154
Cumulative **	6,374	

Source: Disability Control File/Comprehensive Work Opportunity Support System (DCF/CWOSS)

* Each year counts people who generated at least one payment to an EN during that fiscal year.

** Figures do not add up; the cumulative total includes all beneficiaries who had at least one month off the rolls in any year and removes duplicates.

- # Ticket beneficiaries who have had benefits suspended and/or left the rolls due to work and earnings*

FY 2002	7	
FY 2003	95	
FY 2004	232	
FY 2005	534	
FY 2006	856	
FY 2007	1,061	
FY 2008	1,416	
FY 2009 (through 05/31/09)	1,541	Est. for FY 2009 = 2,312
Cumulative **	2,737	

Source: Disability Control File/Comprehensive Work Opportunity Support System (DCF/CWOSS)

* Each year includes individuals who had at least one month off the rolls during that fiscal year.

** Figures do not add up; the cumulative total includes all beneficiaries who had at least one month off the rolls in any year and removes duplicates.

- # months for which benefits were not paid due to work and earnings

FY 2002	7	
FY 2003	533	
FY 2004	1,783	
FY 2005	4,761	
FY 2006	7,756	
FY 2007	9,416	
FY 2008	13,337	
FY 2009 (through 05/31/09)	10,741	Est. for FY 2009 = 16,112
Cumulative	48,334	

Source: Disability Control File/Comprehensive Work Opportunity Support System (DCF/CWOSS)

Program costs/savings

- Program savings

To date, we have completed an evaluation of the first two years (2002-2003) of the Ticket program. We were unable to find any statistically significant savings that we could attribute to the Ticket program during this two-year period. We are currently analyzing whether there are longer term savings that we can attribute to the Ticket program.

- Program administrative costs (including staff support/contracts, etc.)

We expect a cost benefit report this summer (2009) from our TTW evaluation contractor, Mathematica Policy Research (MPR). In their draft of that report, MPR estimates that ongoing TTW operations in FY 2008 will cost approximately $27.8 million and that there will be a one-time cost of $1.8 million associated with the additional efforts required by the Program Manager for Recruitment and Outreach to "re-start" the TTW program in response to the new TTW program regulations. These estimates represent only the costs associated with implementing aspects of TTW that were new and went beyond our existing system for paying State VR agencies; they do not include the reduction in administrative costs associated with the suspension of Continuing Disability Reviews (CDR) under the TTW program nor do they consider the changes in the administration of the traditional payment system for State VR agencies resulting from the TTW program.

4. Can the Agency determine whether individuals who returned to work under the Ticket Program would have returned to work anyway? If yes, how?

For the first two years (2002-2003) after the TTW rollout began, our evaluation contractor, MPR, was able to determine whether individuals who returned to work under the TTW program would have returned to work anyway. The contractor did this by using a statistical approach that compared beneficiary work in States with the TTW program to those in States without the program. These early results showed no

statistically significant increase in work due to the TTW program. We do not know whether these results were because the TTW program was not effective or because not enough time had passed for significant work outcomes to occur that we could attribute to the TTW program. MPR described these findings in detail in Chapter 12 of the 4th TTW evaluation report (September 2008).

We are currently developing an approach to answer this question beyond the second year of the TTW program. Using information from several State VR agencies, we plan to identify a comparison group of beneficiaries who are interested in work but who are not receiving employment services. We will compare these beneficiaries to beneficiaries receiving TTW services from an EN or State VR agency. This should allow us to determine whether statistically significant numbers of beneficiaries who returned to work under TTW would not have returned to work in the absence of TTW. We plan to include this analysis in our 2010 TTW evaluation.

5. **Detailed information about the number of SSI recipients working in particular programs, along with their annual earnings, is available in the annual SSI statistical report. When will similar detailed information be available for the Ticket program? How many SSI recipients participate in a work or vocational rehabilitation program and never get to the point where they have earnings? What's going on in the states that have a higher percentage of SSI recipients working? And what's going on in the states that have a low rate?**

We have not examined the long term earnings of all SSI recipients who participate in a work or vocational rehabilitation program. We do not have access to participation data for all work or vocational rehabilitation programs available to SSI recipients. As our focus in the TTW evaluation has been outcomes after TTW assignment, we analyzed earnings following TTW assignment and the extent to which SSI recipients participating in the TTW program have worked at a level sufficient to generate a milestone or outcome payment to an EN.

Milestone-Outcome Beneficiary Payment Profile—
Types of Payments Generated by Tickets Assigned in First Three Years After TTW Rollout:

	DI/Concurrent		SSI	
	Number	Percent	Number	Percent
Tickets Assigned in First Year Following Rollout (February 2002-January 2003)				
Tickets assigned	1,358		600	
Tickets generating any payment in months 0-11	226	16.6	71	11.8
Tickets generating any payment in months 12-23	138	10.2	37	6.2
Tickets generating any payment in months 24-35	85	6.3	20	3.3
Tickets generating any payment in months 0-35*	255	18.8	73	12.2
Tickets not generating any payment in months 0-35	1,103	81.2	527	87.8
Tickets Assigned in Second Year Following Rollout (February 2003-January 2004)				
Tickets assigned	1,696		631	
Tickets generating any payment in months 0-11	323	18.6	67	10.1
Tickets generating any payment in months 12-23	189	11.1	42	6.7
Tickets generating any payment in months 0-23*	353	20.8	78	12.4
Tickets not generating any payment in months 0-23	1,343	79.2	553	87.6
Tickets Assigned in Third Year Following Rollout (February 2004-January 2005)				
Tickets assigned	2,497		1,053	
Tickets generating any payment in months 0-11	422	16.9	134	12.7
Tickets not generating payment in months 0-11	2,075	83.1	919	87.3

Source: Ticket Research File, December 2005, and MPR tabulations of SSA administrative data.
*In determining the totals for all months, we count each ticket only once even if used in more than one period.

We are working with MPR on a more comprehensive analysis of what happens to SSI recipients following participation in a work or VR program. We do not require SSI recipients to report when they are participating in a work or VR program. We are limited to examining those recipients who assign their tickets under the TTW program and those recipients who participate in a VR without assigning their tickets (using SSA data matched with Department of Education data from the VR program). We will determine how many SSI recipients enter employment services and what then happens to them, including whether they have earnings or exit from our benefit rolls. MPR will include the results of this analysis in the 6th TTW evaluation report, which they expect to issue in mid-to-late 2010.

What's going on in the states that have a higher percentage of SSI beneficiaries working? And what's going on in states that have a low rate?

We have not looked at these issues as part of the TTW evaluation. However, we are participating in a research project sponsored by Cornell University's Employment

Policy Research and Rehabilitation Training Center and funded by the Department of Education, National Institute on Disability and Rehabilitation Research. In this study, we are examining the differences in employment rates of disability beneficiaries (both SSI and SSDI) across States and over time. We expect to have the study results by late 2009.

Overpayments/Continuing Disability Reviews (CDRs)

6. **In his testimony, John Kregel notes, "Frustratingly, SSA continues to devote extensive resources to an intractable administrative problem that continually gets worse and worse. The fear and reality of overpayments actually causes many beneficiaries to reduce and curtail their employment efforts. Many others experience extreme financial hardship as they and their families are forced to repay monies they erroneously received, even though they complied with every reporting deadline in a timely and accurate manner."**

   What is the Agency doing to prevent overpayments? Rather than giving additional work to already overwhelmed field office staff, has the Agency considered using a dedicated, centralized unit for the Ticket Program participant's work CDR process to result in better service?

   We use several different processes and software components to obtain work information and process reports of work and earnings.

   The Social Security Protection Act requires that we provide work report receipts to disability beneficiaries. We use the eWork system to generate those work report receipts, as well as to control Title II work reports until we take final action on them. The eWork software helps us in the intake, development, processing, and control of work issues from the initial report of work activity to final processing. eWork is a nationally accessible, web-based system that replaces our prior system and provides expanded functionality.

   The Disability Control File (DCF) houses data regarding work activity and other disability-related information. We use the DCF to store information on work activity for disability beneficiaries and to control certain processing actions. We also use the DCF in conjunction with our CDR Enforcement Operation (CDREO) to help identify when a disability beneficiary has wages or self-employment income reported in the Master Earnings File, but we have not yet conducted a review of that work activity. We control CDREO alerted cases with the DCF until we take final action.

   We query the Office of Child Support Enforcement's new hire database for both Title II and Title XVI disability applicants and beneficiaries via online access, and we have a batch operation for Title XVI. The new hire database allows us to identify unreported work activity more quickly, because we access it quarterly. We are studying the effectiveness of using a batch operation for Title II that will work similarly to the CDREO system.

The SSI Automated Telephone Wage Reporting System (SSITWR) makes it easier to report monthly wages. Using SSITWR, the public can report wages without having to mail pay slips or contact a field office directly. This new system is available nationwide. We require our employees to inform beneficiaries of the SSITWR during post-eligibility, wage-related contacts, pre-effectuation reviews, and redeterminations.

We considered using a centralized unit to process work CDRs for Ticket participants when the Ticket program began. However, because we consider all work CDRs equally important, we determined we would need a very large centralized unit to cover work CDRs nationwide. In addition, local offices can often work with local employers to obtain needed information and are in a better position to obtain other detailed information from an employer than a large, out-of-area centralized unit.

7. **Does the Agency give any priority to work CDRs generated by those who voluntarily report their earnings? Can the SSA's system identify work CDRs that are generated by self report as opposed to earnings enforcement or third party report? The Agency estimates that each dollar spent on a CDR saves about $10 in lifetime program savings. Do work CDRs yield similar savings?**

   We consider all work CDRs equally important and do not give priority to one type over another. We do not have a system available that can identify work CDRs that are generated by self-reporters or third party reporters. A claims representative would know by reviewing a case whether or not wage information was self-reported, an enforcement, or third party report, but we do not have a report available that can provide that information. We do not have an estimate for the ratio of program savings to administrative costs for conducting work CDRs. The agency does not track this data.

8. **How many work CDRs are completed in the payment centers during a given year? How many are returned to the field offices for additional development during that same year? How long does it take for the payment centers to determine that additional field office assistance is necessary?**

   Since our payment centers do not track this data precisely, we do not have validated data for the number of work CDRs they process. We are currently working on establishing a more accurate way to count work CDRs processed in our payment centers.

   We do not capture how many work CDRs are returned to the field offices for additional development or how long it takes the payment centers to determine if additional field office assistance is necessary.

9. **If a work CDR confirms an overpayment, does the system provide any information on whether there was an Internal Revenue Service (IRS) alert and/or an Agency alert for a possible work CDR in prior year(s)?**

   Yes, we record and maintain a history of each work enforcement alert on our DCF.

10. **What are the criteria used to select cases for further review ("Agency alert") from the list generated by the IRS alert?**

    First, we remove all cases with earnings less than the trial work period service month level for the specific enforcement year, regardless of the medical diary code.

    For the remaining cases, the process compares the earnings revealed via the enforcement process against set thresholds. The threshold amounts are different based on the Medical Diary Reason: Medical Improvement Expected (MIE), Medical Improvement Not Expected (MINE), and Medical Improvement Possible (MIP). The process also checks for verified earnings on the DCF. A case will be alerted under the following conditions:

For MIE Diaries	For MIP, MINE or No Diaries
Enforcement earnings must be at least one month of substantial gainful activity (SGA) for that enforcement year AND There must be a difference of one month of SGA between the Enforcement Earnings and Verified Earnings on the DCF.	Enforcement earnings must be at least six months of SGA for that enforcement year AND There must be a difference of one month of SGA between the Enforcement Earnings and Verified Earnings on the DCF.

11. **What are the criteria used to select the approximately 175,000 cases for a work CDR from the list of approximately 522,000 generated by the Agency alert?**

    The 522,000 figure is not the universe for the work CDRs; it is the number of agency alerts. Based on the criteria explained in question 10 above, some of these alerts are developed to become work CDRs and some are not. Unlike medical CDRs, which are scheduled and conducted based on the probability of medical improvement, the agency processes work CDRs as we receive evidence that a recipient is earning above our established minimum level.

12. For the most recent year available, what was the total amount of overpayments resulting from work CDRs? Of the amounts overpaid, what was the dollar amount of overpayments waived and the amount of overpayments recovered?

Since we do not track medical and work CDRs separately, we do not have specific data to answer this question conclusively. We estimate that about 80 to 85 percent of overpayment dollars identified in fiscal year 2008 as a result of a disability cessation can be attributed to work activity. This would equal about $600 to $700 million. We also estimate that about 20 percent of disability cessation overpayments are waived.

We do not have information on the percent of overpayments recovered or the value of those recoveries. However, in tracking some overpayments over a period of time, we found that about 50 percent of disability cessation debts had been recovered after a period of 10 years.

13. In her testimony, Ms. Suter stated: "We are committed to reducing the likelihood of overpayments, and we are collaborating with all stakeholders to develop proposals to ensure that beneficiaries who report their earnings timely will not be penalized for our delays in processing their work CDR." What options is the Agency considering? Will individuals be permitted to keep the overpayment?

As Ms. Suter testified, we want to simplify our work incentives for disability beneficiaries to reduce the likelihood of overpayments. Since we are in the earliest stages of formulating proposals to address this issue, it would be premature to discuss any specific options under consideration. We would be happy to work with Congress to develop proposals aimed at reducing these overpayments.

In some cases, our current policy allows people to keep overpayments. We can waive recovery of an overpayment if both of the following conditions are met: the person is without fault in causing the overpayment and recovery of the overpayment would either defeat the purpose of the Social Security Act or be against equity and good conscience.

14. Please provide the following data with respect to overpayments:

- **The average amount overpaid due to work activity during the Extended Period of Eligibility (EPE).**
- **The average amount overpaid following a work cessation.**
- **The average amount overpaid due to work activity that is ultimately recovered.**
- **The average amount overpaid due to work activity during the Extended Period of Eligibility (EPE).**

This information is not available.

- **The average amount overpaid following a work cessation.**

  Based on an informal study done in 2007, disability cessation overpayments attributed to work activity in 2004 through 2006 averaged about $11,000 to $12,000.

- **The average amount overpaid due to work activity that is ultimately recovered.**

  Please refer to our response to question 12.

Demonstration Projects

15. The Benefit Offset National Demonstration (BOND) project is infamous for being consistently delayed and well over budget. What lessons learned by the 4 state pilot can be applied to the national demonstration project? What additional information does SSA expect to gain from the national rollout of the project? What precautions are being taken to ensure the project does not run further over budget? Is the SSA currently implementing any of the recommendations put forth in the March 2009 Social Security Office of the Inspector General report? Given the Agency's experiences with BOND, what policies have changed and what precautions have been taken to ensure that future demonstration projects will not be well over budget or delayed?

What lessons learned by the four-state pilot can be applied to the national demonstration project?

We initiated the four-State pilot to learn more about the process of administering a benefit offset in a way that will be an effective work incentive for beneficiaries. The four States are working on final reports that will document the full set of lessons learned from the project. We are applying the lessons learned to the BOND, and we will share these reports with the Subcommittee when we receive them.

Some of the important lessons we learned are:

- The process used in the four-State pilot was too labor intensive, and benefit adjustments were not always performed in a timely manner, resulting in overpayments to beneficiaries. We are working with Lockheed Martin to develop an automated benefit offset payment system that should help us administer the benefit offset on time, minimize overpayments, and avoid the payment errors made in the four-State pilot.

- Specialized Work Incentives and Planning Assistance (WIPA) services are important for beneficiaries to understand the benefit offset program. Our final BOND design plans include testing the specialized WIPA services developed by the four States in combination with the benefit offset, as well as testing a benefit

offset that does not include WIPA services. This will give us the ability to quantify differences in outcomes and provide important information for a cost-benefit analysis.

- We can improve benefit offset notices by making the notices easier to read, increasing automation that ensures notices will be timelier to prevent overpayments, and targeting additional notices specifically for BOND participants.

- Offsetting rather than ceasing benefits resulted in increased employment among the small sample of volunteers selected to participate in the project. The pilot only focused on a small sample of volunteers, because the primary purpose was to test the administration of an offset before implementing the national demonstration. We are unable to produce reliable estimates of the benefits and costs that would occur under a national program from this small sample of volunteers.

What additional information does SSA expect to gain from the national rollout of the project?

We expect to obtain information to estimate direct costs and benefits of a benefit offset for a nationally representative sample of beneficiaries who entered the program under the current program rules.

Our final demonstration design will not directly measure two other issues:

- The costs that may occur if the new benefit offset program induces individuals with a disability to enter the SSDI program who otherwise would not have (referred to as induced entry); and
- The net savings from imposing an offset on earnings below the SGA level (referred to as earnings disregard).

We decided not to use a demonstration project to measure these two issues after our research and analyses revealed that a demonstration project is not a practical way to accomplish this measurement. A team of expert consultants, the Ticket to Work and Work Incentives Advisory Panel, and our design contractor, Abt Associates, Incorporated, confirmed our research and analyses.

However, we can use the data from BOND to provide policymakers with some information on both induced entry and on the net savings from an earnings disregard. We plan to use data from the national demonstration to assess the amount of induced entry that could occur before the costs outweigh the benefits.

We also plan to use the data to develop improved model-based estimates for the two issues described above. With a model-based approach, we must make certain assumptions regarding beneficiary behavior. Actual data from the BOND project will

help us to assess whether these assumptions are reasonable and whether there are more realistic assumptions that we should use for this approach.

What precautions are being taken to ensure the project does not run further over budget?

We have made several changes over the course of the last two years to minimize the risks of cost overruns. As noted in the Office of the Inspector General (OIG) report, the cost estimates for the project under prior management were very large, and the project design was very complicated; it also included an early intervention, expanded health benefits, coordination with Department of Labor One Stop entities, and individualized employment support accounts. We worked with Abt Associates, Inc. to simplify the design so that it measured the effect of a benefit offset only, i.e., more in keeping with the legislative mandate. This resulted in lower cost estimates and fewer risks of cost overruns when compared to previous design plans.

We received the final deliverables from Abt Associates, Inc. on the design contract prior to the contract ending in September 2008. We decided to delay awarding the evaluation and implementation contract until we had sound plans for automating the benefit offset payment process. Our work with Lockheed Martin on the automated benefit payment process has gone very well, and we are now ready to move forward with the procurement of an evaluation and implementation contract. We plan to have an automated benefit payment process ready for release in August 2010; this will minimize further delays and the associated cost overruns.

We decided to use a full and open competition procurement process to award the implementation and evaluation contract, instead of the sole source procurement process specified in the original design contract. A full and open competition process often results in a contract award that is the best value to the government. This decision is consistent with a recommendation of the OIG.

Is the SSA currently implementing any of the recommendations put forth in the March 2009 Social Security Office of the Inspector General report?

Yes, we are implementing all of the recommendations in the March 2009 OIG report. We have restructured the implementation and evaluation contract to allow the evaluation to be conducted by an independent party, as recommended by OIG. We have also changed our acquisition strategy from a sole source acquisition, as specified in the design contract, to full and open competition.

Given the Agency's experience with BOND, what policies have changed and what precautions have been taken to ensure that future demonstration projects will not be over budget or delayed?

We have established more effective management controls, have identified potential risks to the budget earlier in the lifecycle of a project, and will make necessary project

changes to minimize the possibility of cost overruns. We will assess the benefits and costs of a change to a project to ensure that we are not jeopardizing the quality of the information gained from the project.

16. As mentioned above, the BOND demonstration project is infamous for cost over runs. How many other currently running demonstration projects are over budget? Which projects are these and by how much?

None of our other projects are experiencing cost overruns. As detailed in the last part of question 15, we have taken actions on other projects to minimize the risk of cost overruns.

17. In a September 2008 audit of management control over SSA demonstration projects, the Government Accountability Office found that the Agency continues to lack management controls to ensure that the demonstration projects yield reliable information for making disability policy decisions. The Agency acknowledged a need to develop a guidebook to assist staff in the design, implementation, and evaluation phases of its demonstration projects. Has this guidebook been completed?

At the time of the Government Accountability Office (GAO) audit, our existing guidebook did not contain as much information as GAO recommended. However, we did have in place various management controls that we had not yet documented in writing. We are currently expanding the guidebook, per GAO's recommendation, to document our procedures in writing. We expect to complete the guidebook update within the next three months.

Ticket Program

18. Ms. Suter's testimony indicates that state workforce investment agencies and boards have become Employer Networks (ENs), resulting in 119 One-Stop locations providing return to work services to SSA disability beneficiaries. Does this result in federal funding from one agency (SSA) being used to reimburse other federal spending (by the One-Stops)? What is the total of Social Security Trust Fund and/or general revenue funding that has been used to reimburse One-Stops?

Under the Ticket Program, we do not reimburse ENs (including One-Stops) for services. Rather, we pay ENs for employment results in accordance with work milestones or outcomes achieved by the beneficiary. To date, the total dollar amount of EN payments to the current EN One-Stops is $219,039. We defer to the Department of Labor concerning how One-Stops use Ticket payments.

19. Ms. Suter's testimony includes this statement, "If after a review of these programs [WIPA and PABSS] a decision is made to pursue reauthorization, we will work with Congress to reauthorize funding." Who is completing this review, who is making the decision, and when will that information be shared with Congress?

We conduct ongoing review of both programs. Based on this review, we are confident that both programs are fulfilling their congressional mandate to help our beneficiaries with disabilities. Our authorization to fund these programs ends on September 30, 2009. We are currently considering whether to propose extending this authorization.

20. What is the annual cost for the marketing contract awarded to Cherry Engineering Support Services, Inc. and how long do you expect this contract to last?

The cost of the contract with Cherry Engineering Support Services, Inc. (covering the period from November 30, 2008, to November 29, 2009) is approximately $4 million. Our current contract has an additional option year, and we expect to exercise this option. The contract will end on November 29, 2010. We will evaluate the performance of the contractor and our needs for recruitment and outreach of the Ticket Program early next year to determine whether we will need to solicit for a new Program Manager for Recruitment and Outreach contractor beyond November 29, 2010.

21. Background information provided to the Committee indicates State Vocational Rehabilitation (VR) agencies were reimbursed $546 million over fiscal years 2003 through 2008. Were all of these claims reimbursed under the Ticket to Work program? If not, how much per fiscal year can be attributed to the Ticket program? How much of the Ticket portion would have been reimbursed to VRs if the Ticket program had not been in operation?

We reimburse these claims under our Vocational Rehabilitation Reimbursement Program, not the Ticket to Work program.

We paid the following amounts to State VR agencies acting as ENs, which is not the same as State VR agencies reimbursed under our Vocational Rehabilitation Reimbursement Program:

	Amount	Total Payments	Milestone Payments	Outcome Payments
FY 2003	$39,471	122	51	71
FY 2004	$124,597	368	116	252
FY 2005	$406,878	1,178	251	927
FY 2006	$681,041	2,002	272	1730
FY 2007	$884,758	2,479	331	2148
FY 2008	$1,245,764	3,512	383	3129
Total	$3,382,509	9,661	1,404	8,257

Source: Disability Control File/Comprehensive Work Opportunity Support System (DCF/CWOSS)

22. A number of legislative suggestions were raised at the hearing, most notably additional demonstration authority, work incentive improvements, adjustment to earnings validation requirements, work opportunity tax credit increase, and funding from Community Development Financial Institutions managed by the Department of the Treasury. Is the Agency reviewing these suggestions for consideration for submission to the Congress? Please separately provide the results of your review to the Subcommittee once it is complete.

We are considering legislative suggestions for the demonstration authority, work incentives improvements, and earnings validation requirements. The other witnesses' testimony did not provide enough information for us to consider legislative suggestions regarding the work opportunity tax credit increase and the Community Development Financial Institution or even assess whether SSA would be the appropriate originator of such legislation. We will provide the results of our review when completed.

SOCIAL SECURITY

Office of Retirement and Disability Policy

AUG 2 5 2009

The Honorable Diane E. Watson
Chairwoman, Subcommittee on Government Management,
Organization, and Procurement
Committee on Oversight and Government Reform
House of Representatives
Washington, D.C. 20515

Dear Chairwoman Watson:

Thank you for your letter of August 3, 2009, requesting additional information in order to complete the record for the hearing on "E-Verify: Challenges and Opportunities," held on July 23, 2009. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Angela Arnett, our Acting Deputy Commissioner for Legislative and Regulatory Affairs, at (202) 358-6030.

Sincerely,

David A. Rust

Enclosure

Questions for the Record Subsequent to the July 23, 2009, Hearing Before the House Committee on Oversight and Government Reform, Subcommittee on Government Management, Organization, and Procurement

1. **What is the number of citizens who need to update their record of name changes with the agency each year but fail to do so?**

   We do not know how many people change their names each year but fail to notify us of the change. We update or correct our records whenever a person applies for a replacement card, applies for benefits, or requests a change to the record. Even though we cannot require people to notify us of changes in their information, we encourage them to do it. The instructions attached to each Social Security card state that the card holder should contact us if his or her name, citizenship, or alien status changes because these changes may affect current or future Social Security benefits.

2. **What would be the actual costs incurred by employers to participate in E-Verify if the program were to operate on a user-fee basis?**

   The Department of Homeland Security (DHS) is responsible for administering the E-Verify program, so we defer to DHS regarding its total cost to run the program and how those costs would translate to employer costs should Congress require DHS to charge a fee to use the program.

3. **If participation in E-Verify becomes mandatory for employers, how would SSA's field offices be impacted in terms of additional costs and the need for more personnel?**

   We are preparing a preliminary estimate on the effects of a mandatory E-Verify program on our agency. Once we finalize our estimate, we will immediately provide the information to you. The preliminary estimate will represent the costs if the current E-Verify system is expanded. Any changes to the current process could have significant additional costs to the agency.

   In addition to direct costs, there are indirect costs associated with a mandatory program. Any action we take in resolving a tentative non-confirmation is time our employees cannot use to assist applicants for a Social Security benefit. Due to the aging of the baby boomers and the current economic downturn, our offices are already straining to keep pace with increasing numbers of Social Security claims. Any significant increase in visitors to our field offices related to E-Verify could lead to longer waiting times for applicants for Social Security benefits.

   The field office workload related to tentative non-confirmations of the E-Verify system falls disproportionately on certain States. Last year, our California, Arizona, and Texas field offices handled more than 40 percent of this E-Verify workload.

It is vitally important that, should Congress make the program mandatory, we have adequate funding and lead-time to increase our field office capacity. At the end of this month, we will implement a much-anticipated systems upgrade to more efficiently process the expected increase in E-Verify queries should the program be mandated for all new hires. However, to ensure that we effectively support the E-Verify program without compromising our ability to handle our mission critical workloads, a mandatory program should be phased-in over a multi-year period.

4. **Is the federal government prepared to begin checking the identity and/or work eligibility of all federal workers?**

   We defer to DHS regarding the capability to expand the E-Verify program to all Federal workers.

5. **With the implementation of the September 8, 2009 deadline for registering federal contract workers, will contractors who work at the state and local government levels also have to begin registering in order to work on federally-funded contracts (i.e., stimulus-funded transportation projects)?**

   We defer to DHS regarding the requirements for contractors to verify work eligibility.

SOCIAL SECURITY

The Commissioner

February 5, 2010

The Honorable John S. Tanner
Chairman, Subcommittee on Social Security
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your December 15, 2009 letter requesting additional information to complete the record for the hearing on clearing the disability claims backlogs. This hearing was held on November 19, 2009. Enclosed you will find the answers to your questions.

I hope this information is helpful. If we may be of further assistance to you or your staff, please do not hesitate to contact Judy Chesser, our Deputy Commissioner for Legislative and Regulatory Affairs, at (202) 358-6030.

Sincerely,

Michael J. Astrue

Enclosure

4. **From what states were cases shifted in FY 2009? From what states do you expect to shift cases in FY 2010?**

   In FY 2009, the following 17 States sent claims to other offices for adjudication: Alaska, California, Colorado, Kansas, Louisiana, Michigan, Missouri, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Pennsylvania, South Dakota, Tennessee, Washington, and Wisconsin.

   In FY 2009, the following 26 DDSs sent claims to other offices to obtain medical ratings only: Arizona, California, District of Columbia, Florida, Georgia, Hawaii, Illinois, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Nevada, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

   Since the DDS workloads and staffing levels can fluctuate, it is difficult to project workload transfers. We expect to see an increase in the number of transfers in FY 2010 due to our increased capacity to provide nationwide assistance. To ensure we provide resources to those States most affected by the surge in initial claims, we will analyze workload data on an ongoing basis.

5. **How many cases are being shifted from one state to another? Please break down by initial claims, reconsiderations, and continuing disability reviews (CDRs). How does SSA track these cases?**

   Thus far in FY 2010, there have been 2,786 claims transferred to and from State DDSs for determinations and medical review. These transfers included the following States: Alabama, Arizona, Georgia, Illinois, Indiana, Michigan, Minnesota, Nebraska, South Carolina, and Tennessee.

   Since we currently use a manual reporting process that does not classify claim transfers by type, we do not have a ready breakout of the number of initial, reconsideration, and continuing disability reviews (CDR) that the States have transferred. We plan to formalize the claim transfer report process, thereby allowing us to more precisely track transferred workloads.

6. **With respect to processing time, reductions in pending levels, and accuracy, what benefits have resulted from SSA's ability to shift cases between states?**

   Transferring claims allows us to maximize the use of all available resources, reduce the impact of State furloughs, reduce waiting times in the State and Federal adjudicating components, and achieve and maintain manageable caseloads and accuracy.

Extended Service Teams

7. When does SSA expect the four Extended Service Teams to start processing cases?

The Extended Service Teams (EST) are currently completing hiring, training, and site preparations. The Arkansas EST will begin processing claims early in the third quarter of FY 2010. We expect the other three ESTs (Mississippi, Oklahoma, and Virginia) to start processing claims by the end of the third quarter of FY 2010.

8. How many cases will be assigned to each team in FY 2010? Please break down by initial claims, reconsiderations, and continuing disability reviews (CDRs).

We do not have a precise number of claims that we intend to assign to each EST at this time. We will assign the number of claims to the ESTs based, in part, on the number of employees assigned to the EST and the learning curve necessary for new disability examiners in each EST.

We created the ESTs to assist those States most affected by the initial claims surge; therefore, the ESTs will focus on initial claims. Furthermore, it takes a new disability examiner approximately two years to be fully trained in processing the full range of claims. Since we will staff the ESTs primarily with new examiners, we do not expect them to process reconsiderations or CDRs, which are more complex claims, in FY 2010.

9. How are cases assigned to the Extended Service Teams?

We will compile and analyze specific workload and performance data to determine to which States national resources will be directed. We will determine the level of assistance each State needs and where capacity exists among the ESTs. When assigning claims to the ESTs, we will consider a number of factors, including the ESTs' locations relative to the State(s) being assisted (due to time zone differences), as well as the ESTs' capacity levels.

10. What is the expected processing time for initial claims processed by these teams?

The ESTs will adopt the business processes of the States they are assisting; consequently, we expect their processing times to be similar to those States. We will closely monitor the ESTs' processing times, using the same metrics we use when we monitor State DDS processing times.

11. What was the allowance rate for initial claims, averaged over FY 2007 through FY 2009, in each of the four states chosen to house Extended Service Teams? How does this compare to the allowance rate nationally over the same period?

The chart below contains the requested information.

	FY2007	FY2008	FY2009	Average
National	**34.6%**	**36.0%**	**36.9%**	**35.8%**
Arkansas	34.3%	36.1%	37.1%	35.8%
Mississippi	23.4%	24.5%	26.6%	24.8%
Oklahoma	37.9%	39.7%	38.6%	38.7%
Virginia	39.7%	39.0%	40.4%	39.7%

Expanding Federal Capacity

12. How many cases did SSA shift from state DDSs to Federal adjudicators in FY 2009, and how many cases does SSA anticipate shifting to Federal adjudicators in FY 2010? Please break down by initial claims, reconsiderations, and continuing disability reviews (CDRs). How does SSA track these cases?

In FY 2009, State DDSs transferred a total of 44,513 claims to Federal adjudicators. The breakdown of claims was as follows:

	Initial	Recon	CDR
Nation	36,008	2,347	6,158

In FY 2010, Federal adjudicators will focus primarily on initial claims, thereby assisting States that have been greatly affected by the initial claim surge. Since Federal components are increasing their staffing, we expect them to increase their production with a goal of deciding 64,000 claims this fiscal year.

To track these claims, we use manual management information (MI) reports compiled by our regional offices. The regional offices send these reports to Headquarters for consolidation into a workload database.

13. What was the average processing time in FY 2009 for initial claims processed by Federal adjudicators? What does SSA expect the average processing time to be for such cases in FY 2010?

In FY 2009, the Federal adjudicators' initial disability claim processing time was 104.2 days for Title II claims and 99.8 days for Title XVI claims.

We expect average Federal adjudicators processing times to be slightly higher than processing times for DDS initial disability claims because of increases in initial claims and the learning curve for new employees.

14. What was the allowance rate for initial claims, averaged over FY 2007 through FY 2009, for Federal units processing DDS workloads?

	FY 2008	FY 2009	Average
Nation	36.0%	36.9%	36.5%

We did not track allowance rates or other MI for DPBs until FY 2008. Federal units have only recently begun to focus on initial claims.

15. With respect to processing time, reductions in pending levels, and accuracy, what benefits have resulted from SSA's ability to shift cases from states to the Federal level?

We have experienced benefits similar to those described in our response to Question 6.

Quick Disability Determination and Compassionate Allowance Initiatives

16. Please provide, for each of the categories listed below: 1) the percent of total initial claims it represents (not including technical denials); and 2) the average processing time in FY 2009 and projected for FY 2010.

- **Quick Disability Determination (QDD) cases**
- **Compassionate Allowance (CAL) cases**
- **Cases not identified as QDD or CAL (excluding technical denials)**
- **All initial claims (excluding technical denials)**

Table 1 provides the percent of total initial claims by QDD or CAL category for FY 2009 and our projections for the end of FY 2010. Since we were unable to accurately exclude technical denials, we did not exclude them from our estimates.

Table 1. Percent of total initial claims by QDD/CAL category

Category	FY 2009*	FY 2010**
QDD only claims	2.2%	2.7%
CAL only claims	0.4%	0.5%
Both QDD and CAL claims	1.0%	1.3%
Total QDD and CAL claims	3.6%	4.5%
Claims not Identified as QDD/CAL	96.4%	95.5%
All Initial Claims	100%	100%

* CAL began on October 27, 2008; therefore, these data represent the percent of cases for all of FY 2009 beginning with October 27. Our Annual Performance Plan goal for FY 2009 was 3.8, which we met, but that goal is for the last month of the fiscal year not the entire year, hence the discrepancy in the two numbers.

** Projections for last month of FY 2010. Our FY 2010 performance measure is to achieve 4.5 percent of initial disability claims identified as QDD or CAL for the last month of the fiscal year. We do not have a performance measure encompassing the entire fiscal year because we are incrementally increasing the volume of claims identified for QDD and CAL throughout FY 2010. We expect that the incremental

increase will result in an average for FY 2010 of 4.1 percent of total initial claims identified as CAL or QDD.

Table 2 displays the available information for average DDS processing times for CAL/ODD claims.

Table 2. Average Disability Determination Services (DDS) Time, FY2009

Category	Days	Comments
QDD	11.7	This time represents claims that were identified as "QDD" claims and claims that were both "QDD & CAL."
CAL	12.3	This time represents claims that were identified by the predictive model (PM) that were "CAL only" and claims that were both "QDD & CAL."
CAL Manual	5.8	This time represents claims that were manually identified as CAL. It is possible that some of these claims were also QDD.

17. According to SSA's "Justification of Estimates for Appropriations Committees" for FY 2010, SSA's budget supported a total of 14,369 DDS work years for FY 2009 and 15,128 for FY 2010. What were the total DDS workyear savings in FY 2009 resulting from the QDD initiative? From the CAL initiative? What are the total DDS workyears savings anticipated in FY 2010 due to each of these initiatives?

QDD and CAL help those who are clearly disabled by reducing the time their claims are pending in the DDS, but these initiatives do not affect task times and we do not realize any workyear savings.

18. If the QDD and CAL initiatives were not in place, how many of these cases would have resulted in appeals to the hearings level, thereby contributing to the hearings backlog?

We estimate that, for FY 2009, approximately 2,060 cases, or two percent of the cases, selected for CAL and QDD would have gone to the hearing level in the absence of those processes.

Hearings Backlog Reduction Plan

19. Ms. Kennelly's testimony states that, due to updated workload projections, SSA will need to expand its corps of Administrative Law Judges (ALJs) to 1,600.

You testified that you plan to have about 1,450 ALJs on board by the end of FY 2010. Do you agree that an additional 150 ALJs will be needed to handle the coming surge of appeals that will hit SSA's hearing offices, while still keeping on track with the hearings backlog reduction plan?

Based on our review of projected claims, this fiscal year we adjusted our target ALJ corps from 1,250 to 1,450. We may change that target level in future years after a careful review of updated receipt projections and ALJ productivity data.

Hiring ALJs is a lengthy and difficult process that requires the assistance of the Office of Personnel Management (OPM). We appreciate the attention that John Berry, the Director of OPM, has placed on this issue. In December 2009, OPM opened the register for new applicants. It is imperative that OPM move quickly to provide us with a list of suitable candidates so that we can hire the necessary ALJs and support staff to maintain our progress at working down the backlog. OPM has informed us that we will not be able to obtain a certificate from the ALJ register until early May, making it difficult for us to meet our hiring targets by the end of the fiscal year.

20. **If additional ALJs (beyond 1,450) are needed, when would you like to have these ALJs on board? How many additional support staff will you need to hire, beyond attrition, to ensure that these additional ALJs are fully productive?**

We continually reassess projected hearing requests and other factors, and we will adjust the number of ALJs we hire and our support staff as necessary to ensure we meet our goal to eliminate the hearings backlog and prevent its recurrence.

21. **You said that in FY 2010 you plan to maintain a hearing office staff-to-ALJ ratio of at least 4.5 to 1. Have you done any studies or analyses to assess whether 4.5 to 1 is the right ratio to ensure that each ALJ is as productive as possible? Might a higher ratio be a more cost-effective way to achieve the goal of working down the hearings backlog as quickly as possible, while ensuring that the time of highly-paid ALJs is used in the most effective manner?**

As with the 500 annual disposition expectation for ALJs, the 4.5 national average is not a requirement or a quota. We believe that, as long as we can provide the right combination of job functions, including case pullers and writers, an average of approximately 4.5 support staff for each ALJ will allow us to continue reducing the backlog. At some point, there is a diminishing return to additional support staff.

SOCIAL SECURITY

The Commissioner

February 5, 2010

The Honorable Sam Johnson
Ranking, Subcommittee on Social Security
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

Dear Ranking Member Johnson:

Thank you for your December 1, 2009 letter requesting additional information to complete the record for the hearing on clearing the disability claims backlogs. This hearing was held on November 19, 2009. Enclosed you will find the answers to your questions.

I hope this information is helpful. If we may be of further assistance to you or your staff, please do not hesitate to contact Judy Chesser, our Deputy Commissioner for Legislative and Regulatory Affairs, at (202) 358-6030.

Sincerely,

Michael J. Astrue

Enclosure

Questions for the Record
For the November 19, 2009 Hearing
On Clearing the Disability Claims Backlogs
Questions from Representative Sam Johnson

1. **Please provide a detailed explanation and accompanying timeline explaining what needs to be done, by when, and at what cost regarding the replacement of the COBOL-based computer programs. Also, why aren't performance goals related to this and other technology improvements included in the Performance and Accountability Report?**

   There are solid business reasons for us to transition our COBOL systems to more modern programming languages. Modern languages provide flexibility for incorporating modern technologies. In addition, most of the employees we are hiring now and will hire in the near future work with web-based systems, and these web technologies are more user-friendly.

   We have made solid progress in our modernization efforts. We are converting the databases that contain enumeration, earnings, benefit, and demographic data to modern, industry-standard databases. We have already converted two-thirds of these data and will complete the rest by 2012. During our conversion process, we run the new and old databases parallel to each other for several months to mitigate risk and minimize disruptions of daily operations. So far, we have had no outages, processing delays, or lost data. We build all of our new systems using modern languages, such as JAVA. Currently, 40 percent of our software inventory is in JAVA, and it is the standard language we now use for writing software code.

   Rather than simply rewriting our COBOL code, we are taking the opportunity to redesign our systems for the 21st century. For example, we are currently replacing the 54 COBOL systems used by State disability determination services (DDS). If we merely rewrote these systems using JAVA, we would end up with 54 independent web-based systems with many of the same limitations we have today. Instead, we are building one common web-based system that all DDSs can use and that integrates case-analysis tools and health information technology. While it takes longer to create a common system, we believe that it is time well spent, and we will end up with a more efficient system.

   Since replacing COBOL is interconnected with related systems upgrades and redesigns, we cannot break out the costs of replacing COBOL from those activities.

   Below is our current timeline for shifting our programs and applications into a more modern infrastructure:

   - **Electronic Disability Applications** - Completed
   - **Modernized Enumeration System** - Completed

- **Disability Control File** – Fiscal year (FY) 2011 Completion
- **DCPS (DDS Systems)** – FY 2013 Completion
- **Legacy Administrative System** – FY 2014 Completion
- **Unified Earnings Correction Process** – FY 2014 Completion
- **Wage Reporting Backend Processing** – FY 2014 Completion
- **Title II Modernized Claims System** – FY 2014 – 2017 (Phased development to minimize risk)
- **Modernized Title XVI Claims System** – FY 2014 – 2017 (Phased development to minimize risk)
- **Earnings Use System** – FY 2014 – 2017 (Phased development to minimize risk)

Pursuant to Office of Management and Budget (OMB) guidance, our performance goals in our Performance and Accountability (PAR) report are all tied directly to our strategic goals set out in the Agency Strategic Plan (ASP). While we considered improvements to our information technology (IT) infrastructure to be a foundational element needed to achieve all of our strategic goals, we did not consider these improvements themselves to be strategic goals. Accordingly, we did not include any performance goals for IT improvements in our PAR. Nevertheless, we did specifically address our need to replace the 54 COBOL-based DDS systems in Goal 2 of our ASP. We discuss our plans to implement a common case processing system for the DDSs in our ASP on page 11 and provide a description of this outcome on page 14. (See attachment.)

2. Please update the Subcommittee as to:

- **The status and operational capacity of the data center in Durham.**

That data center, which we refer to as the Second Support Center (SSC), opened in January 2009 and is fully operational as a major IT center, serving our IT operations 24 hours a day, 7 days a week. In May 2009, we began processing mission critical workloads at the SSC.

The SSC now contains:

- Medical images for electronic disability folders;
- Four mainframe computers;
- Billions of characters of data storage;
- Magnetic tape robots to create backup copies of critical data and provide the capability to use those copies to restore that data in the event of data corruption or data loss;
- Fully-redundant telecommunications connections to all of our offices, the Internet, and the National Computer Center (NCC) in Woodlawn, Maryland;

- A mirrored IT operations control center synchronized with the NCC; and
- A full-time staff of about 120 employees and contractors.

When we moved these workloads to the SSC, we reduced our potential data loss by 50 percent. We also improved our ability to sustain operations because the SSC supports our employees' access to:

- Our network and the Internet in all offices;
- Essential Blackberry communications services;
- E-mail (including access from the Internet);
- Connectivity to SSANet for traveling employees; and
- Our program policy web-site.

The SSC also houses one of four service delivery points for our new Voice over Internet Protocol (VoIP) telephone system. At this time, it is the primary site for approximately 100 offices and can assume full operation of VoIP in the event of a disaster at the NCC site.

- **The date when the Agency will have enough hardware and software in Durham to bring up claims and data processing systems should there be a catastrophic event at the National Computer Center in Baltimore and whether Durham will be able to take on 100% of the National Computer Center work at that time.**

By the end of calendar year 2012, the SSC will be able to restore services within 24 hours in the event of an NCC disaster, and the systems will be current within one hour of the disaster.

To mitigate the vulnerability between now and the end of 2012, we have purchased the hardware and software necessary to support the claims and data processing systems presently housed in the NCC. This equipment is now operational. In the event of a disaster at the NCC, we would take the backup tapes to the SSC and use them to restore operations. It would take 7 days to restore services; however, once up, we would be able to handle all claims and data processing workloads and would not have to ration services to either our employees or the public.

From January 2010 to July 2010, we will refine and test our current disaster recovery procedures to utilize the SSC rather than a commercial hot site. Thereafter, we will perform an actual disaster recovery exercise in the SSC.

By the end of October 2010, the necessary physical infrastructure will be operational to support our non-critical workloads. Non-critical workloads have lower priority and include management information, forecasting, cyclical, regional, and end-user developed applications. In the event of a disaster, we will be able to bring up these non-critical workloads within a couple of weeks.

We will fully synchronize our data centers by the first half of 2012. Fully synchronized data centers will provide a failsafe in case of problems due to the aging NCC infrastructure. Even with full synchronization, though, the SSC could not restore services within 24 hours in the event of an NCC disaster until the end of 2012.

- **Once Durham has the capability to restore full computer operations and in essence serve as the primary data center for the Agency, what impact, if any, will this have on the replacement of COBOL-based programs?**

  Since we will build any new or converted applications to run in either the SSC or the NCC, the SSC will not affect our initiative to replace COBOL-based programs.

3. **Experts have told the Agency that the National Computer Center will no longer be viable after 2012, and $500 million has been made available for a new computer center. According to staff reports, that center is expected to be completed by October 2013, but all systems won't be up and running until July 2015, six years from now.**

   - **Are you satisfied with this timetable?**

     I believe we should have started on this activity earlier but we are moving as fast as we can consistent with high quality work. Since Lockheed Martin (LM) issued its February 8, 2008, report on the NCC, we have implemented several initiatives at the NCC to reduce risks until our new data center is operational. LM noted in its evaluation that we managed and executed our facility maintenance practices ably and that practice should continue to sustain the NCC beyond 2012.

     In March 2009, when we received approval to build the new data center, we immediately began working with the General Services Administration (GSA) to develop a timeline for the project. The timeline follows Federal procurement guidelines and incorporates expedited methods to complete the process without compromising quality. We continue to work with GSA to track the project and, where possible, will implement additional expedited processes. The timeline is:

     February 2010 - Select Site
     March 2010 - Purchase Site
     March 2011 - Award Design-Build Construction

October 2011 - Start General Construction (full building construction)
October 2013 - Substantial Completion
November 2013 - Final Commissioning and Punch List corrections
January 2014 - Complete Commissioning
July 2015 - Complete IT migration

To sustain infrastructure support for IT operations until calendar year 2014 or later, we have initiated or completed the following projects:

- We continue to perform maintenance during the annual shut-down on Columbus Day.

- We purchased spare Uninterruptible Power Supply (UPS) parts in April 2009. The service provider agreed to extend the maintenance contract on the UPS system through 2015.

- In May 2009, we replaced critical electrical feeders between the Utility and NCC building to avoid possible failure due to age and deterioration.

- We will complete a 3-phase NCC Riser Panel project to upgrade electrical capacity by July 2010, replacing 256 electrical riser panels. We completed phase one over the 2009 Columbus Day weekend. Additional shutdown dates are:

  - President's Day weekend 2010
  - Memorial Day weekend 2010
  - Independence Day weekend 2010 (contingency date)

- We will install additional UPS Risers (for computer equipment) and general house power risers (for additional cooling equipment) by or before January 2011 based on opportunities to shut down operations.

- We will renovate and expand the SSN Card Print Room by June 2010.

In 2009 we invested in projects ranging from redesigning space within the NCC to upgrading the power by adding four additional feeder cables (two for the data center and two for house power). The feeder upgrade will allow us to install an additional 80 servers in the NCC. Reconfiguration and renovations to the NCC inner core have resulted in approximately 4,000 square feet of available space for the additional server cabinets necessary to support our workloads by September 2010.

In each fiscal year, we have a placeholder for $500,000 to renovate and improve the NCC. In FY 2010, we have an additional $300,000 to establish a new Security Operation Center lab. In FY 2011, we have a placeholder for $18

million for design and construction of new air handlers if needed. We expect the existing air handlers will remain operational until 2015.

- **If not, what's being done about it?**

  We are making changes as quickly as we can, given funding limitations, consistent with doing the work well.

- **Are building plans still within budget? Please update the Subcommittee as to what all costs are projected to be, by general category.**

  The project remains within the estimated budget. Although the specifics of the estimated costs remain confidential to ensure the equity, fairness, and integrity of the GSA procurement process, to date we have issued $2.1 million in Reimbursable Work Authorizations to GSA for planning activities. Other costs include $14 million for site acquisition and $2.4 million for site studies related to the National Environmental Building Act and utility needs.

- **The Office of the Inspector General (OIG) is planning a thorough review of the progress of the new national computer center as they are required to do by law - yet they are waiting for specifications from your Agency. Please explain this delay.**

  We have not found any request for specifications from OIG that had not already been provided. We are currently consulting with OIG staff to ensure they receive all information necessary to complete their review.

4. **Please provide the Subcommittee with information regarding how requests for technology changes are processed within the Agency:**

   - **What information is included in the request, and how are cost, savings, schedule, and performance goals included?**

     Our IT Advisory Board (ITAB) handles requests for human resources for technology investments. The Chief Information Officer (CIO) chairs the ITAB, and its membership comprises our most senior executives. Every request to the ITAB includes a statement of the objective and scope of the investment and an estimate of required resources developed by the Office of Systems. Development project requests also include a cost-benefit analysis or business-value analysis.

     We organize these investments by portfolios. Each portfolio is aligned with an Agency Strategic Objective, is sponsored by a Deputy Commissioner, and is supported by a portfolio management staff led by a senior executive or other designee.

We are currently undertaking changes in our processes that will move responsibility for the process from Systems to the CIO.

- **Who reviews the requests, and what criteria are used to evaluate each request?**

The portfolio management staff and the Office of Systems review every request for resources. If a request will also benefit a component other than the sponsoring component, that component also reviews the request. In every case, the staff reviews basic information including the investment's purpose or objective, the expected cost, the expected benefit (quantitative or qualitative), an assessment of the risk, and other factors.

Since the objectives of the portfolios vary, the portfolio management staff and sponsor determine the weight to be given the different criteria. For example, the decision to make an investment to reduce disability processing times will weigh heavily on the return-on-investment in terms of labor savings; while an investment designed to improve our financial accounting transparency is likely to weigh heavily on cost and the extent to which the investment is aligned with our strategic and tactical approach.

- **How are priorities determined?**

We determine priorities at two levels—the ITAB level and the portfolio level. Every April, ITAB members allocate resources to each portfolio based on a review of the portfolio's strategic importance relative to other portfolios for the upcoming year. The portfolio's objective and our goals shape this review. They consider many other factors, including the portfolio's objective and whether there are major investments currently underway that require additional resources for completion.

At the portfolio level, each portfolio management staff ranks proposals within its purview and allocates resources to them according to the judgment of the sponsor and staff. Since the portfolio sponsor is also responsible for attaining that portfolio's agency strategic objective, this approach ensures that the technology investments are in line with our overall approach to that strategic objective.

- **What follow-through is completed after the request is fulfilled to verify whether projected savings have occurred and whether the information included in the request was accurate?**

Currently, our follow-through reviews happen at two levels—the Office of Systems conducts a post-release review (PRR) after completing an ITAB project, and the CIO conducts a post-implementation review (PIR) for some projects. The PRR focuses on the systems development process and the end users' acceptance of the product. Our CIO has developed a framework for conducting PIRs, which

are broader reviews that address business outcomes as well as a full assessment of the costs and benefits. The CIO will develop a specialized staff to manage IT investment performance measures. This staff will integrate PIRs into the overall investment management process and apply the lessons learned to improve the quality of subsequent projects.

5. **An OIG report entitled Opportunities and Challenges for SSA (A-08-09-29152) issued to Chairman Tanner and Chairman Lewis included the following statements regarding verifying information technology investment results:**

"As a part of the Agency's ITAB process, SSA typically estimates the potential number of full-time equivalents (FTE) and related dollar savings that will result by implementing IT projects. As indicated in the chart below, in FYs 2007 through 2009, SSA reported that between 58 and 84 new and continued projects would save at least 68,650 FTEs over a 7 year period. The projected dollar savings for these projects were significant-ranging from about $10 to $20 billion over a 7-year period."

"While the projected FTE and dollar savings are impressive, we are concerned that these estimates are not realistic and do not reconcile to SSA's annual productivity statistics. For example, if SSA saves almost 70,000 FTEs over a 7-year period, the Agency ostensibly could use 10,000 FTEs each year to increase productivity in other SSA workloads. Using 10,000 of the Agency's approximately 60,000 FTEs (or 17 percent) for other workloads should result in significant productivity increases in areas that may have been previously neglected because of a lack of resources. Yet, in FY 2007, SSA recorded a productivity increase of only about 2 percent. While this may be a simplistic example of a far more complex process, the disparity between the projected FTE savings and actual productivity increases is marked."

"Accordingly, we believe post-implementation reviews (PIRs) would enable the ITAB to determine whether many of the IT projects it assessed and approved resulted in SSA achieving the projects' functionality and cost savings. Furthermore, without verification of this information, the ITAB cannot demonstrate that the Agency is receiving value for its IT investments. In response to a draft of this report, SSA stated that, beginning in April 2009, it will have a process in place to ensure PIRs are performed on incremental releases of larger projects."

Why did post-implementation reviews not take place? Please describe the process now in place to ensure these reviews are being done. Is this process in place for all projects?

As explained in our answer to the prior question, we have only recently begun implementing the PIR process. We have developed a PIR framework and executed our

first two PIRs using that framework. With the additional resources we are committing to this effort, we will conduct PIRs to assess whether the reviewed project achieved the functionality and cost savings originally estimated.

Going forward with the revisions to the ITAB we will be designating certain initiatives as subject to a PIR. The designation may happen at initiative initiation or at any point in the life cycle. The initiatives will be selected based on factors such as size, cost, complexity, strategic criticality, and technological innovativeness. Basically, we will select the ones that are most risky or strategically critical, and we will select those that we could learn the most from. We are now developing the guidance to support the selection and oversight process.

Explain the process by which transfers are made from administrative funds to the SSA's IT budget each year:

- **How are decisions made in terms of what amounts are transferred and how IT funds are spent?**

  The first step in our annual IT budget formulation process is to determine the overall level of IT funding required for the fiscal year. Then, we review the level of unobligated administrative funds from prior fiscal years that we could transfer to the IT account before determining the level of new budget authority that we will request for the year.

  We spend IT funds on hardware, software, telecommunications, and contractor support for our systems work. The CIO maintains the IT project list, which allocates IT resources to the many new and ongoing automation projects that we undertake.

- **What amounts have been transferred in each of the past five years?**

  The table below lists the transfers for the past five years:

Fiscal Year	Transfer ($ millions)
2005	$ 80
2006	$142
2007	$184
2008	$168
2009	$170

7. **With respect to those workers filing claims due to the recession:**

   - **Were these individuals previously working with a disability? Or are workers filing for benefits as a last resort?**

We have not conducted a targeted study to determine the reasons for the surge in disability benefit applications due to the recession; therefore, we do not know whether the applicants were previously working with a disability, applied for benefits as a last resort, or sought disability benefits due to a state statutory requirement or for some other reason.

- **Will more claims be denied in the short-run?**

  Since more disability claims were filed in FY 2009 as a result of the recession, there will be both more denials and more allowances. However, at this time, our Chief Actuary assumes that the additional applications will not significantly affect the percentage of disability applications that are ultimately allowed.

- **What quality reviews are in place to ensure eligibility decisions are accurate?**

  To ensure that disability decisions are correct, we conduct the following quality reviews:

  - Quality Assurance Reviews: We review a random sample of 70 denials and 70 allowances per DDS per quarter. This review provides a measurement of the DDSs' decisional accuracy.

  - Pre-Effectuation Review: The Social Security Act requires us to perform a targeted review of 50 percent of initial and reconsideration allowances.

  - Random Denial Review (RDR): We began this review of a random sample of denial cases from each DDS in December 2008. The approximate annual sample size for FY 2009 was 40,000 cases.

  - Targeted Denial Review (TDR): The TDR will sample denial cases with higher than normal probability of error. We will begin a gradual rollout of this review early in calendar year 2010. Ultimately, it will replace the RDR. When we complete the rollout, we expect the yearly sample size to be the same as the RDR sample.

  - Senior Attorney Advisor (SAA) Review: We conduct a post-effectuation quality review of SAA fully favorable decisions. This review has been in existence for about 2 years and consists of a national random sample of 85 fully favorable SAA decisions per month.

8. **The FY 2009 appropriation included funding (a base appropriation of $264 million and an adjustment for an additional $240 million) to conduct continuing disability reviews which save $11 for every $1 invested, according to the President's 2010 budget request. You said in your testimony (page 14) that the number of full medical Continuing Disability Review (CDRs) pending is expected to reach 1.5 million this year.**

- **How much money could be saved by working down this backlog?**

  Since the financial effects of doing CDRs vary depending on the mix of cases reviewed in a given year, it is very difficult to estimate the additional savings that might result from working down the current backlog of CDR cases. However, based upon our experience over more than ten years, we estimate that every dollar spent on medical CDRs yields at least $10 in lifetime program savings.

- **What is your plan to address this backlog?**

  The FY 2010 President's Budget provided an additional $485 million in a discretionary allocation adjustment (above the cap) for our program integrity efforts in FY 2010. With this additional funding, we will be able to continue to reverse the overall decline in completing our key program integrity workloads. We are pleased that Congress included the full amount of the President's request for program integrity work in the enacted appropriations legislation.

- **Given the focus on processing other growing workloads, how can you assure the Subcommittee that these critical program integrity workloads that save billions and increase taxpayer confidence will not take a back seat to other work as they have in the past?**

  The FY 2010 appropriations legislation specifies that we may use the additional $485 million for designated program integrity work only; thus, we cannot use these funds to process initial claims or other work and will use it solely for program integrity work.

- **What can Congress do to help?**

  Congress can help us protect taxpayer dollars by continuing to provide timely, sustained, adequate funding so that we can effectively balance our service and stewardship work. With the additional funding Congress provided to us in FY 2009, we were able to increase our program integrity efforts as well as process more claims and hearings for the American public. Since we received full funding of our FY 2010 budget, we will be able to process over 30 percent more medical CDRs than we completed in FY 2008.

9. **You have worked with Disability Determination Services (DDS) parent agency heads and other State executives, including Governors, to try to prevent State furloughs and hiring freezes. To your credit, you have had some success.**

   - **What have you learned?**

     We have learned the value of consistent communication and education, which have been common factors in each success story. We have provided governors,

legislators, and State officials with information explaining the unique relationship that we have with the DDSs, emphasizing the fact that DDSs are fully federally-funded. We have provided the States with examples of the consequences of a one-day furlough on the States, the DDS employees and, most importantly, the citizens with disabilities in the States. We have shared this information in personal conversations with governors and in interviews with the media. In addition, our Regional Commissioners have had similar conversations with governors, their staffs, and legislators. Our DDS administrators and their parent agencies have educated the governors and legislators as well.

In addition to personal contacts, I have sought and received the support of the Vice President Biden in an effort to increase this issue's visibility. Vice President Biden strongly expressed to the NGA the need for governors to make the right decision and exempt federally-funded agencies from destructive furloughs and hiring freezes. In several instances, our unified efforts to educate the States have been successful. Even in States with furloughs, we have been largely successful in avoiding hiring freezes. Through our efforts and those of the DDS administrators, we have been able to get hiring approved on a case-by-case basis in those States where we have not been able to avoid a hiring freeze. Unfortunately, in many States, budgetary, political, or labor considerations have led to full or partial furloughs in spite of our efforts. In addition, we are learning that many states are proposing pay cuts, reducing benefits, and initiating early retirement incentives.

- **Are there changes to regulations or to the law that are being considered to prevent this from happening in the future?**

  At this time, we have just started considering whether there are any regulatory changes that could strengthen our hand here, but much of this area is governed strictly by statute. The Administration has not proposed legislation to address the issue. However, we are eager to work with Congress to prevent future furloughs and hiring freezes. These state budget strategies will result in the loss of experienced staff and lower morale, which will ultimately diminish service provided by the DDSs.

10. During this past fiscal year ending in September, the Agency hired over 9,100 employees. When attrition is factored in, the net number of new hires is about 4,200.

- **Are these numbers correct?**

  In FY 2009, we hired approximately 8,600 new full-time permanent employees, including new State DDS employees. This was our largest hiring effort since the implementation of the SSI program over thirty-five years ago. Along with that hiring, we also maximized the use of overtime across the agency. Overall agency

attrition was about 4,400 full-time permanent employees, including State DDS employees. The net number of new full-time employees was 4,200.

- **Please provide more detail regarding the positions for which individuals were hired and where the positions are located.**

  Out of the total 8,600 full-time permanent hires, more than 6,400 were front-line positions directly related to processing workloads such as claims representatives in field offices, teleservice representatives in our teleservice centers, and disability examiners in the State DDSs. In addition, we hired about 1,350 full-time permanent employees for hearings offices, which includes a net increase of 87 administrative law judges (ALJs) as well as the necessary support staff.

  For more detailed hiring information, please refer to the charts (attachment) that follow these responses. The numbers in the charts represent our employees (not just our full-time permanent hires) and exclude DDS hires. Therefore, the totals differ slightly from the figures above.

- **Will all of these hires serve on the front lines directly processing claims?**

  The vast majority—over 90 percent—were hired to serve on the front lines handling claims, hearings, or in other capacities directly serving the public.

11. Please describe any additional process changes you are considering in the early stages of claim filing to reduce the number of decisions that are appealed.

In addition to the process changes discussed at the hearing, we have also established the Integrated Disability Process (IDP). The IDP is a multi-component initiative that will enable us to address and resolve important disability policy and procedural issues. The process will also help us address differences and difficulties in applying policy and procedures at all adjudicatory levels. The IDP team is working to simplify, clarify, and streamline some of the most complex policy issues in the disability program, including the assessment of past relevant work, the content of the medical source statements, and the creation of a Unified Disability Training Package.

Currently, ten States are testing a modification to the disability process that eliminates the reconsideration step. We are considering reinstating the reconsideration step in these States, which would reduce the number of hearing requests we receive. We are also considering a rule change to permit DDS disability examiners to make fully favorable determinations without requiring the input of a medical or psychological consultant in certain disability claims.

12. It has come to my attention that there have been continued delays by the SSA in revising the medical listings as they apply to individuals affected by Huntington's Disease. I'm told that in 2004 the SSA began the rule-making process to revise the medical criteria for all neurological conditions, but there have since been multiple delays. I am also told that the final guidelines will be

issued no sooner than December 2010 with implementation likely to occur in 2012. This is not acceptable. Please provide a summary of what has happened, the current status, and the reason for delay.

Updating our listings is an important part of streamlining our disability claims process, and we strive to update them as quickly as possible. We have found that revising the neurological body system Listings, which include Huntington's Disease, has posed unique challenges and has proven much more difficult than we originally anticipated. We understand that the delay in publishing new guidelines has been frustrating for many stakeholders.

To clarify a point in this question, we do not plan to issue final guidelines for the neurological listings in December 2010. Rather, in December 2010, we plan to publish a Notice of Proposed Rule Making (NPRM), which invites public comment on our planned revisions.

We published an Advanced Notice of Proposed Rule Making (ANPRM) for the neurological listings on April 13, 2005. The comment period for the ANPRM ended on June 13, 2005. We received almost 300 separate public comments in response to the ANPRM, which raised a wide variety of neurological impairment and adjudicative issues we need to address. In July 2005, we also held a public outreach conference in New York City, where we received additional comments from patients, medical experts, and advocates, including the Huntington's Disease Society of America.

Neurological impairments include many different kinds of disorders; we have 17 adult and 9 childhood neurological listings, several of which include more than one kind of neurological disorder. As we continue to learn more about the diagnosis, symptoms, and treatment of neurological disorders with outreach hearings, such as with the Compassionate Allowances initiative, we try to incorporate what we have learned into the revision.

We are taking other steps to improve all of our Listings. Under our strategic plan, we will update all Listings as needed at least every 5 years. We also have an ambitious effort underway to expand the listings to include many rare diseases and conditions. Furthermore, we have entered into a 3-year contract with the National Academy of Sciences, Institute of Medicine (IOM), to establish a standing committee of medical experts to ensure that our Listings are medically supportable, relevant, and technologically current. As part of our contract with IOM, the standing committee will evaluate medical literature, major studies, and emerging technologies to inform the agency of potential listings revisions. The IOM will also provide reports on specific body systems that we will use to revise the Listings.

13. **In a November 10th article in the Washington Post ("The Retirement Problem," Johnson and Kwak) an MIT professor and Yale law student tried to use the online benefit calculator for some of their calculations. As Andrew Biggs has**

pointed out, their results were too low because they did not understand that the calculator uses wage-indexed dollars.

- **If a professor and a law student from two prestigious universities cannot use this calculator, how do you expect average Americans to be able to use it for their planning purposes?**

  As part of our commitment to providing the best possible financial planning tools for the public, we unveiled our current online Retirement Estimator in July 2008. Prior to launching the online Retirement Estimator, we conducted focus groups with financial planners and the public. These focus groups looked at the overall usability and understandability of the application and considered carefully the best approach to providing future estimates.

  The Retirement Estimator is simple and interactive, allowing users to compare different retirement options. For example, a person can change retirement dates or expected future earnings to better determine the impact on future benefits and decide the best time to retire. The Retirement Estimator does not display the earnings that are used in the calculation; it displays only benefit estimates.

  We chose wage-indexed values in part because using wage-indexed values allow the public to compare estimated future benefits to their average or recent earnings, and thus have a sense of how much of their earnings will be replaced by Social Security retirement benefits. Adequate replacement rates are typically the goal of retirement planning. The Retirement Estimator uses the same system that produces estimates for the Annual Social Security Statements.

  Our Retirement Estimator has been a huge success. We have provided over four million personalized retirement estimates to Americans since its launch last year. We cannot explain Professor Johnson's and Mr. Kwak's difficulty with the program; customer satisfaction scores have consistently ranked our Retirement Estimator among the highest government-wide applications, according to American Customer Satisfaction Index (ACSI) surveys.

- **Are you looking at any changes to clarify how to interpret its results?**

  We are reviewing the language on the online benefit calculator for possible clarifications of how to interpret its results.

14. Some of our caseworkers have seen a fair amount of inquiries from individuals who have lawyers, saying their lawyers haven't been passing on relevant medical information and/or keeping their clients informed.

- **What recourse do claimants have when this occurs?**

Claimant representatives must comply with our Rules of Conduct and Standards of Responsibility for Representatives (Rules of Conduct). Several of our Rules of Conduct apply to situations where an attorney or non-attorney representative fails to submit relevant medical information or keep the claimant adequately informed about his or her case.

For example, representatives must obtain the information and evidence that the claimant wants to submit in support of the claim and forward it to us as soon as practicable. Representatives also must deal with us in a manner that furthers the efficient, fair, and orderly conduct of the decision-making process. This responsibility includes providing competent representation and acting with reasonable diligence and promptness in responding to our requests for information. Moreover, representatives may not deceive or knowingly mislead claimants regarding their rights under the Social Security Act.

Claimants who have complaints about their representatives should bring them to the attention of their local field office or hearing office. Those offices will investigate the complaint and forward their findings to our Office of the General Counsel (OGC). If the investigation reveals evidence of a Rules of Conduct violation, OGC may initiate an administrative action against the representative and seek his or her suspension (for a period of from one to five years) or disqualification from representing claimants before us.

- **Does the Agency keep track of these complaints?**

We have electronic and paper records of the complaints we receive, but we do not track complaints by the specific violation alleged. Therefore, we do not have any data on the number of complaints alleging that a representative has failed to submit relevant medical information or keep the claimant adequately informed about the claimant's case.

- **Please explain what process is in place for the Agency to address such complaints and share any data summarizing the results of these efforts.**

If OGC files a suspension or disqualification action against a representative, that representative has the right to answer the charges and have a hearing before one of our ALJs. After the ALJ issues a decision, either we or the representative may ask our Appeals Council to review that decision.

If we disqualify or suspend a representative, OGC forwards the representative's name to our regional commissioners and the Office of Disability Adjudication and Review and adds the representative's name to a list of sanctioned representatives. We also forward the name to the office that referred the complaint to OGC. In addition, if the representative is an attorney, OGC will inform the attorney's State court or State bar disciplinary authority of the suspension or disqualification.

Since we do not track complaints by the type of violation, we do not have any data summarizing the number of complaints or subsequent suspensions or disqualifications for violations involving a failure to submit relevant medical information or keep a claimant adequately informed about the claimant's case.

Social Security Administration
Hiring from 10/01/2008 - 9/30/2009 by Region/Position

Region	Position Title	
ATLANTA	*ATTORNEY-ADVISERS	167
	*CLMS REPRESENTATIVES	271
	*CONTACT REPRESENTATIVES	8
	*HR SPECIALISTS	2
	*HRG OFC SYS ADMINR	3
	*READER ASSISTANTS	20
	*STUD INTRS (STEP)	236
	*SVC REPS	359
	ADMINV ASST (OA)	2
	ADMINV LAW JUDGE	14
	ATTORNEY	8
	AUDITOR	1
	BENFT AUTHR	31
	CASE INTAKE TECH	1
	CASE TECHNICIAN	49
	CLAIMS ASSISTANT	1
	CLAIMS AUTHORIZER	17
	CLERICAL AIDE	2
	CLK (STEP)	5
	CRIMINAL INVESTIGATOR	5
	DISABILITY EXAMINER	2
	DISABILITY SPECIALIST	11
	FILE ASSEMBLER	1
	GRAD INTERN (STEP)	1
	INFO CASE TECH/RECEP	1
	INQRY & EXPDTNG SPEC	1
	IVT STUDIO TECH	1
	LAW CLERK	2
	LEGAL ASSISTANT	1
	MAIL CLERK	2
	MANAGEMENT ASSISTANT	1
	MGMT SPRT SPEC	2
	OA ASST	5
	PARALEGAL ANALYST	5
	PERSONAL ASSISTANT	18
	SECRETARY (OA)	1
	SECRETARY TO MOD MGR	8
	SENIOR AUDITOR	1
	SR CASE TECHNICIAN	92
	SR CLMS PROCSNG SPEC	2
	SVC REP/DATA REVW TEC	2
	SYSTEMS COORDINATOR	1
	TECHNL EXPERT	21
	TELESERVICE REP	140
	TSC REP (BLNGL)	3
	Total	1527

Region	Position Title	
BOSTON	*ATTORNEY-ADVISERS	19
	*CLMS REPRESENTATIVES	56
	*CONTACT REPRESENTATIVES	4
	*READER ASSISTANTS	1
	*STUD INTRS (STEP)	73
	*SVC REPS	18
	ADMINV LAW JUDGE	7
	ATTORNEY	3
	CASE TECHNICIAN	20
	CLAIMS DVPMT CLK	3
	CLK (STEP)	1
	CRIMINAL INVESTIGATOR	4
	DISABILITY EXAMINER	8
	GRAD INTERN (STEP)	1
	PARALEGAL SPEC	1
	SR CASE TECHNICIAN	8
	STUDENT TRNE (SCEP)	1
	TECHNL EXPERT	3
	TELESERVICE REP	1
	TSC REP (BLNGL)	5
	Total	237

Region	Position Title	
CHICAGO	*ATTORNEY-ADVISERS	58
	*CLMS REPRESENTATIVES	195
	*CONTACT REPRESENTATIVES	10
	*HRG OFC SYS ADMINR	2
	*READER ASSISTANTS	18
	*STUD INTRS (STEP)	162
	*SVC REPS	193
	ADMINV LAW JUDGE	15
	ATTORNEY	10
	AUDITOR	2
	BENFT AUTHR	40
	CASE INTAKE TECH	1
	CASE TECHNICIAN	33
	CLAIMS AUTHORIZER	10
	CLAIMS AUTHR (TRNE)	5
	CLERK	1
	CLK (STEP)	1
	CONTRC SPEC	1
	DISABILITY EXAMINER	1
	GRAD INTERN (STEP)	4
	HR ASSISTANT	1
	MAINTENANCE INSPECTOR	1
	MGMT SPRT SPEC	1
	OPERNS SUPERVISOR	1
	PERSONAL ASSISTANT	13
	SR CASE TECHNICIAN	36
	STUDENT TRNE (SCEP)	6
	SUPY HUMAN RESCS SPEC	1
	SYSTEMS COORDINATOR	1
	TECHNL EXPERT	19
	TECHNL SUPRT TECH	10
	TELESERVICE REP	54
	Total	906

Social Security Administration
Hiring from 10/01/2008 - 9/30/2009 by Region/Position

Region	Position Title	
DALLAS	*ATTORNEY-ADVISERS	42
	*CLMS REPRESENTATIVES	143
	*CONTACT REPRESENTATIVES	3
	*IT SPECIALISTS	1
	*READER ASSISTANTS	1
	*STUD INTRS (STEP)	179
	*SVC REPS	228
	ADMINISTRATIVE AIDE	1
	ADMINV LAW JUDGE	8
	ATTORNEY	2
	ATTORNEY (GEN)	1
	CASE TECHNICIAN	60
	CHIEF OPERS SUPPORT	1
	CLERK	1
	CLERK (STEP)	1
	CLK (STEP)	4
	CRIMINAL INVESTIGATOR	3
	INFO RECPTNST (OA)	3
	LAW CLERK	3
	PARALEGAL ANALYST	1
	SR CASE TECHNICIAN	38
	STAFF ASSISTANT	1
	STUDENT TRNE (SCEP)	11
	TECHNL EXPERT	22
	TELESERVICE REP	89
	TSC REP (BLNGL)	7
	Total	854

Region	Position Title	
DENVER	*ATTORNEY-ADVISERS	13
	*CLMS REPRESENTATIVES	39
	*CONTACT REPRESENTATIVES	4
	*HR SPECIALISTS	2
	*STUD INTRS (STEP)	32
	*SVC REPS	43
	ATTORNEY	1
	ATTORNEY (GEN)	1
	CLK (STEP)	1
	CRIMINAL INVESTIGATOR	1
	DISABILITY EXAMINER	10
	GRAD INTERN (STEP)	2
	PARALEGAL ANALYST	1
	SECRETARY (OA)	1
	SR CASE TECHNICIAN	3
	TELESERVICE REP	11
	VISUAL INFO SPEC	1
	Total	166

Region	Position Title	
KANSAS CITY	*ATTORNEY-ADVISERS	4
	*CLMS REPRESENTATIVES	50
	*CONTACT REPRESENTATIVES	5
	*HR SPECIALISTS	2
	*STUD INTRS (STEP)	46
	*SVC REPS	32
	ADMINV LAW JUDGE	1
	ATTORNEY	2
	ATTORNEY (GEN)	6
	AUDITOR	2
	BENFT AUTHR	64
	CASE INTAKE TECH	1
	CASE TECHNICIAN	14
	CLAIMS AUTHORIZER	11
	CLAIMS DVPMT CLK	1
	CRIMINAL INVESTIGATOR	1
	DEBTOR CONTACT REP	8
	DISABILITY EXAMINER	6
	DISBLTY PROCSNG SPEC	12
	GRAD INTERN (STEP)	3
	INTERPRETER (SGN LNG)	1
	LAW CLERK	1
	LEAD DISAB PROC SPEC	1
	PARALEGAL ANALYST	2
	SECRETARY	1
	SR CASE TECHNICIAN	10
	SR CLMS PROCSNG SPEC	3
	STUDENT TRNE (SCEP)	2
	TECHNL EXPERT	2
	TELESERVICE REP	40
	Total	334

Attachment for Question 10

Social Security Administration
Hiring from 10/01/2008 - 9/30/2009 by Region/Position

Region	Position Title		Region	Position Title	
	*ATTORNEY-ADVISERS	127		INVTRY MGMT SPEC	1
	*CUSTOMER SERV TECH	95		IVT STUDIO TECHNICIAN	2
	*HR SPECIALISTS	25		LAW CLERK	17
	*IT SPECIALISTS	399		LD FACLS MGMT SPEC	1
	*READER ASSISTANTS	5		LEAD IT SPECIALIST	4
	*SOC INS SPECIALISTS	38		LEGAL ASSISTANT	19
	*STUD INTRS (STEP)	213		LEGAL INTERN (STEP)	3
	ACTUARY	3		MAIL CLERK	4
	ADMIN SPECIALIST	2		MANAGEMENT ANALYST	29
	ADMINV ASST	1		MANAGEMENT ASSISTANT	2
	ADMINV LAW JUDGE	2		MATERIALS HANDLER	3
	ATTORNEY (GEN)	12		MATH STATISTICIAN	2
	AUDIT MANAGER	1		MECHANICAL ENGINEER	1
	AUDITOR	9		MGMT & PRGM ANALYST	4
	BENEFIT NOTICES CLERK	2		MGMT ANALYST (HIST)	1
	BENEFITS & ERNGS ASST	6		MGMT ASST	1
	BENFT TECHNL EXMNR	172		NURSE CONSULTANT	1
	BENFTS ERNGS TECH	6		OFFICE AUT CLK (STEP)	1
	BNFTS & RECDS TECH	22		OPRS RESEARCH ANALYST	1
	BUDGET ANALYST	5		PHYS SECURITY SPEC	4
	CARPENTER	2		PIPEFITTER	2
	CENTER DIRECTOR	3		PLUMBER	1
	CHIEF INFO OFFICER	1		PRESDNTL MGMT FELLOW	14
	CLERK	1		PRF STF MBR, SS ADBD	1
	CLMS TECH EXMNR	61		PRINT PRODN SPEC	1
	COMPUTER ASSISTANT	3		PROGRAM ANALYST	11
HDQTRS	COMPUTER SCIENTIST	4	HDQTRS	PROGRAM OFFICER	1
	CONTRACT SPECIALIST	19		PROJECT MANAGER	4
	CORRES MGMT ASST	1		PROPERTY MGMT ANALYST	1
	CUSTODIAL WORKER	1		PUBLIC AFFAIRS SPEC	1
	CUSTODIAL WRK INSPR	1		PURCHASING AGENT	2
	DEPUTY CTR DIRECTOR	2		QUALITY ASSRNCE TECH	2
	DIRECTOR	1		SAFE & OCCUP HEALTH S	3
	DISTRIBTN FCLTS SPEC	2		SECURITY ANALYST	2
	DIVISION DIRECTOR	3		SOC INS POLICY ANALS	1
	ECONOMIST	3		SOC SCI RESCH ANALYST	4
	EEO SPEC	2		SPACE MGMT SPECIALIST	2
	ELECTRICAL ENGINEER	1		SPACE MGMT TECH (OA)	1
	EMPLR RPTG TECH	1		SR EE SPEC	1
	ENGINEER (GEN)	1		SR PRJCT MGR	1
	EQUAL EMPLMT SPEC	1		STAFF ASSISTANT	4
	EQUAL EMPLOYMENT SPEC	1		STAFF ASSOCIATE	1
	ERNGS SPEC (TRAINEE)	23		STATISTICIAN	1
	ERNGS, FIN&ENUM CLK	4		STUDENT TRNE (SCEP)	6
	EXPERT	15		SUPR GEN SUPPLY SPEC	2
	FINANCIAL MGMT ANAL	23		SUPVY ATTY-ADVSR (GEN	1
	FRGN BENFT TECHNL EX	2		SUPVY MGMT ANALYST	1
	FRGN CLMS REP	7		SUPY ECONOMIST	1
	GRAD INTERN (STEP)	10		SUPY IT SPECIALIST	3
	HR ASSISTANT	1		TEAM LEADER	3
	HUMAN CAP PROG ADVSR	1		UTILY SYS RPRER OPER	4
	INDUSTRIAL ENGINEER	1		VISUAL INFO SPEC	1
	INVENTORY MGMT SPEC	2		Total	1,534

Attachment for Question 10

Social Security Administration
Hiring from 10/01/2008 - 9/30/2009 by Region/Position

Region	Position Title	
PHILADELPHIA	*ATTORNEY-ADVISERS	51
	*CLMS REPRESENTATIVES	194
	*CONTACT REPRESENTATIVES	7
	*HR SPECIALISTS	1
	*HRG OFC SYS ADMINR	2
	*READER ASSISTANTS	5
	*STUD INTRS (STEP)	173
	*SVC REPS	141
	ADMIN OFFICER	1
	ADMINISTRATIVE AIDE	2
	ADMINV ASST (OA)	1
	ADMINV LAW JUDGE	14
	ATTORNEY	5
	ATTORNEY (GEN)	1
	AUDITOR	2
	BENFT AUTHR	39
	CASE TECHNICIAN	34
	CLAIMS AUTHORIZER	25
	CLAIMS DVPMT CLK	4
	CLERK	1
	DISABILITY EXAMINER	4
	EE RELS SPEC (BNFTS)	1
	EMPLOYEE DVPMT SPEC	1
	GENERAL ATTORNEY	1
	GRAD INTERN (STEP)	1
	HR SPEC (EE & LBR REL	1
	HR SPECIALIST (RP)	1
	LAW CLERK	2
	LEAD DISAB PROC SPEC	1
	LEGAL ASSISTANT	1
	MANAGEMENT ANALYST	1
	OA ASST	1
	PARALEGAL ANALYST	1
	PERSONNEL STFNG SPEC	1
	POSTENTLMT TECHNL EXP	1
	PRJCT MGR	1
	PROGRAM EXPERT	1
	REGIONAL MGMT OFFICER	1
	REMITTANCE CLERK	2
	SECRETARY	1
	SR CASE TECHNICIAN	61
	SR CLMS PROCSNG SPEC	2
	STUDENT TRNE (SCEP)	2
	SUPY IT SPEC (SYSANA)	1
	SYSTEMS COORDINATOR	1
	TECHNL EXPERT	29
	TELESERVICE REP	98
	TSC REP (BLNGL)	30
	WORKER TRAINEE	1
	Total	953

Region	Position Title	
SAN FRANCISCO	*ATTORNEY-ADVISERS	72
	*CLMS REPRESENTATIVES	217
	*CONTACT REPRESENTATIVES	10
	*IT SPECIALISTS	1
	*READER ASSISTANTS	4
	*SOC INS SPECIALISTS	2
	*STUD INTRS (STEP)	165
	*SVC REPS	224
	ADMINISTRATIVE ASST	2
	ADMINV LAW JUDGE	12
	ATTORNEY	5
	ATTORNEY (GEN)	4
	BENFT AUTHR	64
	CASE TECHNICIAN	118
	CLAIMS AUTHORIZER	6
	CLAIMS AUTHR (BLNGL)	2
	CLAIMS AUTHR (TRNE)	2
	CLAIMS DVPMT CLK	1
	CLERK	1
	CLM DVP CLK (OABLNGL)	1
	CRIMINAL INVESTIGATOR	3
	DISAB PROCSNG SECT CH	1
	DISABILITY EXAMINER	4
	DISABILITY SPECIALIST	3
	ELECTRICIAN	1
	GRAD INTERN (STEP)	1
	HEARING OFFICE DIR	1
	HR ASSISTANT	5
	HR SPEC (R&P/CLSFN)	2
	LANGUAGE INTERPRETER	1
	LD CASE TECHNICIAN	1
	MGMT SPRT SPEC	1
	PARALEGAL ANALYST	3
	PARALEGAL SPEC	1
	PERSONAL ASSISTANT	3
	PROJECT DIRECTOR	1
	SR ATTY-ADVISER	1
	SR CASE TECHNICIAN	2
	SR CLMS PROCSNG SPEC	1
	TECHNL EXPERT	16
	TECHNL SUPRT TECH	1
	TELESERVICE REP	33
	TSC REP (BLNGL)	3
	Total	1,002

Attachment for Question 10

Social Security Administration
Hiring from 10/01/2008 - 9/30/2009 by Region/Position

Region	Position Title	
SEATTLE	*ATTORNEY-ADVISERS	25
	*CLMS REPRESENTATIVES	35
	*CONTACT REPRESENTATIVES	3
	*READER ASSISTANTS	3
	*STUD INTRS (STEP)	39
	*SVC REPS	35
	ADMIN ASST (OA)	1
	ADMINV LAW JUDGE	9
	ATTORNEY (GEN)	2
	BUDGET ANALYST	1
	CASE INTAKE TECH	1
	CASE TECHNICIAN	11
	CLK (STEP)	1
	CLM DVP CLK (OABLNGL)	2
	CONTRC SPEC	1
	CRIMINAL INVESTIGATOR	3
	DISABILITY EXAMINER	6
	DISTRICT MANAGER	1
	GRAD INTERN (STEP)	1
	IT SPECIALIST (SYSADM	2
	LAW CLERK	3
	LEGAL INTERN	1
	PARALEGAL SPECIALIST	1
	SERVICE REP	4
	SR CASE TECHNICIAN	9
	TECHNL EXPERT	5
	TELESERVICE REP	82
	Total	287

Region	Position Title	
NEW YORK	*ATTORNEY-ADVISERS	15
	*CLMS REPRESENTATIVES	202
	*CONTACT REPRESENTATIVES	6
	*HRG OFC SYS ADMINR	1
	*STUD INTRS (STEP)	158
	*SVC REPS	5
	ADMINV LAW JUDGE	9
	ATTORNEY	8
	ATTY-ADVISER (GEN)	1
	BENFT AUTHR	12
	CASE INTAKE TECH	2
	CASE TECHNICIAN	1
	CLAIMS AUTHORIZER	48
	CLMS ASST (OA)READER	1
	CRIM INVESTGR (BLNGL)	1
	CRIMINAL INVESTIGATOR	1
	DISABILITY EXAMINER	7
	FORKLIFT OPERATOR	1
	GROUP SUPERVISOR	1
	INFO CASE TECH/RECEP	1
	LAW CLERK	6
	PARALEGAL ANALYST	3
	PASS SPECIALIST	1
	PERSONAL ASSISTANT	3
	SR CASE TECH	6
	SR CASE TECHNICIAN	31
	STUDENT AIDE	1
	STUDENT TRNE (SCEP)	1
	TECHNL EXPERT	7
	TELESERVICE REP	62
	TSC REP (BLNGL)	21
	Total	623

Total Hires All Regions **	8423

** Includes ARRA & NonARRA hires processed before 10/05/09

SOCIAL SECURITY

January 20, 2010

The Honorable John S. Tanner
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Chairman Tanner:

Thank you for your December 22, 2009, letter requesting additional information to complete the record for the hearing on the Recovery Act project to replace our National Computer Center, held on December 15, 2009. Enclosed you will find the answers to your questions.

I hope this information is helpful. If we may be of further assistance to you or your staff, please do not hesitate to contact Judy Chesser, our Deputy Commissioner for Legislative and Regulatory Affairs, at (202) 358-6030.

Sincerely,

/s/

Michael G. Gallagher
Deputy Commissioner
for Budget, Finance and Management

Enclosure

cc: Susan Brita, Staff Director, Subcommittee on Economic Development, Public Buildings, and Emergency Management of the House Committee on Transportation and Infrastructure

Questions for the Record
For the December 15, 2009 Hearing
On the Recovery Act project to replace the
Social Security Administration's (SSA) National Computer Center (NCC)

Questions from Representative John Tanner

1. **On pages 2, 3, and 28 of GSA's Feasibility Study for the Social Security Administration National Services Center Data Center Facility, dated January 16, 2009, which was a preliminary report on SSA's various options to replace or rehabilitate the NCC prior to enactment of the Recovery Act, it is mentioned that a built-to-suit leased facility would be located in an area 40 miles north and west of SSA's headquarters. The reference on page 28 states that SSA had "preliminarily identified" that area as preferred under "determining drivers" such as density of development, transportation obstacles and technological concerns in other directions.**

   Specifically who at SSA made these determinations and what was the specific rationale for choosing this area?

   In 2008, when we began focused discussions about replacing the NCC, we settled upon a data migration technology that requires proximity within a 40-mile radius of the current NCC. These technology limitations are related to data transmission; this technology assures a lower risk of disrupting service. The primary consideration for choosing this technology was risk mitigation—enabling the successful migration of sensitive data from the NCC to the new data center without interruption of service to the public.

   This 40-mile limitation delineated the area within which we would be able to build the new data center. In August 2008, when the Commissioner received this information, he questioned the recommendation to locate the new data center off campus. Staff had investigated the possibility of building a new data center on the main complex, but found that the campus had limited space suitable for a new facility. In addition, career staff recommended that building on the complex would not be the best option because of topography, parking, and residential property owned by private citizens. Most importantly, we were concerned about the time and money it would take to mitigate these factors given that we were facing NCC electrical capacity issues as early as 2012.

   Given the 40-mile limitation and traffic congestion in the northern Virginia, D.C.-Baltimore area, staff recommended building the new data center in the northwest quadrant of the 40-mile circle. In the event of an emergency, we would need easy access to the data so that we could move it out of harm's way expeditiously and with little disruption to a multi-billion dollar program.

Are these preliminary determinations still considered "driving" criteria in the search for a new location for the National Support Center (NSC)?

The same general criteria (density of development, transportation obstacles, and technological concerns) are included as part of GSA's more detailed site selection criteria, as they are industry best standards and guidelines. Following the advice of the GSA/SSA team, the Commissioner expanded the previously identified wedge area to encompass the full 40-mile radius circle to ensure that any sites meeting the criteria were fully considered. In 2009, the Commissioner convened a meeting to review options for placing the NSC on the main campus, but could not identify an option that would not involve substantial additional costs and delay. At that time, he expressed concern about additional delays given the intent of the Recovery Act to stimulate the economy and jobs growth.

In December 2009, we experienced an event that demonstrated the risk associated with building on site. For three days, the NCC lost the electrical feed from our utility provider. Pursuant to our risk mitigation strategy, we converted to back-up generator power to maintain uninterrupted service. Those generators reside in a location that could be compromised if the new NSC is placed on campus. For example, we were concerned that any new facility would possibly require the relocation of our existing utility lines, which could result in a disruption in power to the entire campus, possibly causing a disruption in service nationwide.

These utility lines provide critical power and chilled water (for cooling) to the current NCC every day. If we were to lose utility-supplied power, we would have to rely on generator power. While this is a viable short-term solution, it is not practical for an extended period.

In addition, the driving criteria posted in the GSA FedBizOps are that:

- The land must be contiguous;
- The land must be within 40 miles of the main complex in Woodlawn, MD;
- The land must provide building space and topography suitable for development;
- The land must have no known landfills, hazardous waste, or soil or water contamination on or near the site for which cleanup would significantly impact the cost or schedule of the project;
- The land must be such that the developable area is not be located within the 100 or 500 year flood plain or have other geological or environmental impairments;
- The land must have reasonable access to power, water, telephone, satellite, and fiber optics, and
- If multiple sites are required, assemblage shall not significantly affect project schedule.

Current site criteria are primarily based on the standards of the following:

- National Environmental Policy Act;
- Telecommunications Industry Association (Uptime Institute follows these standards);

- International Building Code;
- International Fire Code;
- Interagency Security Committee;
- Insurance Services Organization, and
- National Archives and Records Administration.

2. **Cost estimates for this project provided to Congress prior to the Recovery Act, and since, are still considered "preliminary." The Inspector General has raised some questions about them. When will SSA be able to give more definitive cost estimates?**

   GSA will provide us a 50 percent Program of Requirements (POR) from its contractor, Jacobs, in early 2010. We will be able to refine that information. The 50 percent POR will allow us to determine a more definitive cost estimate. Following the established business process, we will reconcile these estimates against the GSA baseline.

   With regard to other smaller but likely significant costs--e.g., IT planning, acquisition, development, and maintenance--we will firm up all estimates associated with the project once we know the location and occupancy date for the new building.

   What are the risks of cost overruns? What are you doing to mitigate these risks?

   We defer to GSA for a detailed response to this question. Certainly, however, a thoughtful architectural plan will minimize the need for subsequent changes, typically the major source of cost overruns in large construction contracts.

   The site location can change the risks associated with project cost and time. Nonetheless, we will continually assess the project and employ risk mitigation strategies to avoid costly, in time and dollars, scope changes. A project team comprised of GSA, Jacobs (GSA's contractor) and SSA staff will monitor and coordinate all project work and provide weekly updates to senior executives.

3. **Please provide an analysis of parking on SSA's campus. How many employees require parking on campus, and how many spaces exist currently? Does SSA ever exceed its parking capacity, and if so, how frequently?**

   The information and analysis below applies to the main complex, i.e., the NCC, the Annex, the Supply Building, the Child Care Center, the Altmeyer and Operations buildings, the East High and Low Rises, and the West High and Low Rises. Excluded from this analysis are other parts of our Central Office, including: Dunleavy, Security West, Metro West, 7111 Boulevard Place, 2525 Lord Baltimore, 3200 Lord Baltimore, Meadows East, Oak Meadows, Preston Gateway Warehouse, Rolling Heights, Rolling Road Commerce Center, Whitestone, Windsor Park, and the Woodlawn Office Complex.

   There are currently 6,252 parking spaces available for about 8,500 employees and contractors who are assigned to the main complex.

Our main complex parking lots regularly come close to, or exceed, capacity. At the lots assigned to NCC employees, we exceed capacity every day. Taking into consideration such factors as leave, training, travel, and alternate work schedules, the days our parking needs are most likely to exceed capacity are Tuesday, Wednesday, and Thursday. For example, parking needs exceed capacity two or three times a month because of meetings, conferences, and other events at the main complex.

What are SSA's short-term and long-term plans to address campus parking needs, including any shortage?

To improve our parking situation, we undertook the following projects in FY 2009:

- Resurfaced and re-striped the NCC parking area in July 2009, increasing the total number of spaces from 680 to 760, adding an additional 80 spaces.
- Relocated heavy vehicle equipment and striped the vacated area, netting an additional 33 spaces at the main complex.
- At the main complex, adjusted reserved parking lot boundaries of spaces for executives, carpools, and employees with medical permits to maximize usage in adjacent unreserved parking lots.
- Funded the construction of two parking areas at the NCC, which will add approximately 185 additional spaces in spring 2010.

These projects allowed us to gain 169 parking spaces in FY 2009 and will increase parking by approximately 185 spaces in FY 2010.

Identifying and planning for future parking will be part of the Integrated Master Housing plan. We are working with GSA to contract a housing and leasing study for the main complex and outlying leased buildings. The housing and leasing study, along with several other campus-wide studies, will shape our Integrated Master Housing plan. Consideration of parking issues will obviously be an important part of this plan.

Has SSA evaluated how many additional spaces would be needed if the NSC were located on campus due to an increase in the total number of employees, and/or the loss of existing parking due to construction of the NSC? What are the results of that evaluation?

GSA is currently working with its contractor to answer this question. We will inform you of the answer as soon as we receive it. We expect, however, that any approach that would involve a substantial use of parking spaces would most likely delay completion of the NSC.

4. **Deputy Commissioner for Systems Bill Gray informed the Subcommittees that the North Carolina facility will "fill the gap" between the time when the NCC is no longer capable of growing and when the NSC is completely functional as the primary datacenter. What are the risks to operations and potential costs involved with this plan?**

We have taken several steps to mitigate these limitations in the NCC and to allow for continued growth. For example, we are replacing power panels throughout the building with greater capacity panels; we have relocated staff, recovering the space and electrical service for computer space, and we have installed more power distribution equipment, increasing our electrical capacity. We can also install new computer equipment in the Second Support Center (SSC) facility as needed. With these measures, we expect no program impact resulting from any inability to install computer equipment until the NSC is available.

In March 2009, we provided GSA through an RWA, $20 million to acquire additional generator and electrical power for the SSC for future IT infrastructure growth. This project is on schedule to be completed by October 2010.

How long could the North Carolina facility function as SSA's only data center, in the event of failure of the NCC?

Beginning January 2010, we can use the SSC in the event of a disaster at the NCC, which is a better option than using a commercial hot site data center, as we would have since the late 1980s. We will test and validate the recovery procedures at the SSC through July 2010.

The SSC could function as our computer facility barring any unexpected, significant change in programs or policies. It is important to note, we have been working since 2002 to divide our IT operations and eliminate the risks inherent in a single IT facility. Should we use the SSC facility as a single "national" computer center, we would have to return to using a commercial hot site for disaster recovery, and the serious limitations and risks of a commercial hot site would return.

5. **What are you doing to extend the useful life of the current NCC to minimize the risk of data processing service disruptions?**

We are continuing our scheduled preventive maintenance to ensure the building infrastructure systems remain fully operational through calendar year 2014, and, if necessary, longer. Following are specific examples of our activities:

- We continue to perform maintenance during the annual shutdown on Columbus Day.
- We purchased spare Uninterruptible Power Supply (UPS) parts in April 2009 and extended a service contract to ensure the UPS system remains operational though 2015.

- In May 2009, we replaced critical electrical feeders between the Utility and NCC buildings to avoid possible failure due to age and deterioration.

- We will complete our NCC riser panel project to upgrade electrical capacity in three phases by July 2010, replacing 256 electrical riser panels. We completed phase one over the 2009 Columbus Day weekend. Additional shutdown dates are:

    - President's Day weekend 2010,
    - Memorial Day weekend 2010, and
    - Independence Day weekend 2010 (if necessary).

- We will install additional UPS risers (for computer equipment) and general house power risers (for additional cooling equipment) by January 2011 when we have opportunities to shut down operations.

- We will expand the SSN Card Print Room to allow for additional inserter machines by June 2010.

Each fiscal year, as we have done in the past, we will renovate and upgrade the NCC as necessary.

Does the increasing utilization of the data center in North Carolina extend the life of the NCC past 2013?

The data center in North Carolina and adaptations to the NCC should extend the life of the NCC, although the risk of a catastrophic failure of the NCC will increase as its infrastructure further ages.

6. Please explain the importance of full redundancy.

Redundancy is important in our critical IT systems because the time required to restore functionality in the event of a failure would have a considerable negative impact on the delivery of services to the American public. That is why we have designed each of our two data centers to be able to restore all of our critical applications within 24 hours if a disaster should hit either one of them.

7. What is a "commercial hot site" and what has been SSA's relationship to such sites?

A "commercial hot site" is a privately owned secure facility to which we can move data and computers if a disaster occurs affecting the NCC. We have relied on hot site contracts since 1987.

8. **What do you envision as a disaster recovery exercise that you mention in your testimony? What will you test? What will constitute "pass-fail"?**

We are currently conducting an annual, two-week disaster recovery exercise at our hot site. This test ensures that we can recover critical IT systems should a disaster occur in the NCC. This is a simulation where we test our ability to:

- Identify, select, and deliver all required recovery data from its secure, offsite data storage facility,
- Use the recovery data to restore our critical systems to computer hardware residing at the hot site,
- Start-up our applications and connect to a small number of field sites which will enter claims data, and
- After completing the test, purge all data from the hot site and safely return the data to secure storage.

The test is a "pass" if our field operations test personnel can enter and process transactions correctly into the systems recovered at the hot site. The transactions are actual, production transactions already processed earlier in the year. The results of the test should match the earlier results. We plan to repeat this exercise at the SSC in the summer of 2010.

9. **The IG testified that the North Carolina facility was initially conceptualized in 2002 as a full backup for the NCC, but when the Commissioner approved of its construction in 2005 the plans reflected a smaller intended role.**

What were the reasons for scaling down the intended role for the second data center between conceptualization in 2002 and start of implementation in 2005? Does this experience suggest that SSA's long-term IT planning process needs improvement or prioritization within the agency?

From inception, we intended that the SSC would serve as a co-processing data center that would run a portion of our production work on a full-time basis. This means that the building does not sit idle waiting for a disaster; rather, it is staffed, maintained, and always ready to assume most of our IT operations in the event of a disaster. In addition, a co-processing design is efficient because there is ongoing use of the resources invested in the facility

In 2008, the Commissioner decided to invest $20 million in the SSC to expand its capabilities to support non-critical as well as critical workloads. While we have a solid IT planning process, we acknowledge that there is always room for improvement. To this end, we established the Future Systems Technology Advisory Panel, comprised of industry experts, to advise us on our future use of technology. In addition, internally, we have strengthened the role and function of our Chief Information Officer to ensure that we have a long-term vision, and the process is in place to make use of leading edge technology.

10. How does SSA evaluate and prioritize IT investments. What evaluation process is applied to determine whether projects achieve their stated purpose?

Our IT Advisory Board (ITAB), led by the Chief Information Officer and comprised of the highest-ranking executives, meets regularly to discuss agency direction, IT strategy, and the priority of IT investments. Every request to the ITAB for resources for a specific IT project includes a statement of the objective and scope of the investment and the Office of Systems' estimate of required resources. Development project requests also include a cost-benefit or business value analysis.

The Office of Systems conducts a post-release review (PRR) after each significant project release. The PRR focuses on end users' acceptance of the product and the systems development process. In addition, our CIO has designed a framework for conducting broader post-implementation reviews. The CIO is developing a staff to manage IT investment performance.

11. On page 1 of your statement, you discuss fundamental changes in the way SSA uses technology. Please outline some of those changes.

Technology is a key element in the way we do business. Here are some examples of change in our use of technology:

Expansion of Public Use Services—We have built a robust suite of Internet applications that the American Customer Satisfaction Index (ACSI) consistently ranks among the best in the Federal Government. ACSI tracks trends in customer satisfaction and provides valuable benchmarking insights of the consumer economy for companies, industry trade associations, and government agencies. ACSI also allows federal agencies to benchmark their performance against comparable best-in-class entities. For the 3rd quarter of 2009, we took the top three spots in the ACSI report card and four of the top seven. Our overall aggregate score was 81.2, tops in Government, and 2.5 points above the second-place finisher.

Paperless Processing—We have gradually eliminated paper from most of our business processes. This has resulted in increased efficiency and better management of the agency. Our most notable paperless activity has been the Electronic Disability Project which literally transformed our extremely complex, paper-based disability claims process. We have established a robust electronic disability folder and various integrated case processing systems that manage our disability work from the claimant's first contact with the agency, to initial claims intake, and through the hearing and appeals levels. These systems also allow us to fast track an increasing number of disability claims.

Expanded Use of Health Information Technology - As we move forward in adopting the use of Health Information Technology (HIT), we will cut the time required to acquire the medical records of disability applicants from weeks to days, in some cases, to minutes. By sending electronic requests to healthcare providers, we can quickly and inexpensively acquire the information we need to assess a claimant's eligibility for benefits. In some cases, when HIT provides all the information necessary, the decision can be made by our examiners in

just a few days. In addition, we will build the capability to analyze the HIT-provided information automatically and provide advice to our examiners on the best way to proceed.

Conversion of User Interfaces and Applications—We are systematically replacing "green screen" user interfaces and applications written in older programming languages with more graphical and versatile screens written in modern JAVA code. These JAVA screens, viewed through Internet browsers, also present new opportunities in posting our applications to the Internet.

Conversion of Databases—We recognized a risk in continuing to maintain our own proprietary software to access vitally important master files that contain earnings, benefit, enumeration, and demographic data. While the data have never been in jeopardy of loss or compromise, we agree with outside experts that it would be wise to convert to a commercially available database management system supported by a strong industry presence. We have already converted three of the five master files previously housed on the proprietary database and will convert the remaining two over the next few years.

12. How many employees are affected by the project to replace the NCC? How many positions will move to the NSC, and how many new positions will be created?

There are more than one thousand employees in the current NCC, none of whom will lose their jobs as result of the new data center. In fact, building the NSC will create jobs, predominately through the construction and ongoing maintenance of the building.

Not all of the employees in the NCC will move to the NSC. The GSA Feasibility Study provided early planning estimates of about 250 employees in the NSC. These estimates are very preliminary. When the POR is completed, we will have a more definitive staffing plan.

SOCIAL SECURITY

The Commissioner

March 3, 2010

The Honorable Sam Johnson
Ranking Member, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Johnson:

Thank you for your January 6, 2010, letter requesting additional information to complete the record for the hearing on the Recovery Act project to replace our National Computer Center held on December 15, 2009. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Scott Frey, our Acting Deputy Commissioner for Legislative Affairs, at (202) 358-6030.

Sincerely,

Michael J. Astrue

Enclosure

cc: Kim Hildred, Minority Staff Director, Subcommittee on Social Security of the House Committee on Ways and Means

Dan Matthews, Minority Staff Director, Subcommittee on Economic Development, Public Buildings, and Emergency Management of the House Committee on Transportation and Infrastructure

SOCIAL SECURITY

The Commissioner
June 12, 2009

The Honorable John S. Tanner
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your letter of April 22, 2009, requesting additional information in order to complete the record for the "Joint Hearing on Eliminating the Social Security Disability Backlog," held on March 24, 2009. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Angela Arnett, our Acting Deputy Commissioner for Legislative and Regulatory Affairs, at (202) 358-6030.

Sincerely,

/s/

Michael J. Astrue

Enclosure

Questions for the Record
For the December 15, 2009 Hearing
On the Recovery Act project to replace the
Social Security Administration's National Computer Center

Questions from Representative Sam Johnson

1. **Please describe in detail how the final decision will be made regarding the location of Social Security's new National Support Center (NSC), including the specific roles of the Social Security Administration (SSA), the General Services Administration (GSA), the Office of Management and Budget (OMB), and the Congress.**

   We have no authority to lease or purchase real estate on our own. GSA has that authority, and we work in concert with them in real estate matters. GSA is expert in real estate and building construction, and we offer our expertise in operations. GSA will manage the site selection, design, and construction activities for the project with input from us. GSA, as the agency responsible for the site procurement action, will then recommend a site to us for concurrence. As required in the *American Recovery and Reinvestment Act of 2009* (Recovery Act), the site selection and construction plan is subject to OMB's review and approval and we will "notify the Committees on Appropriations of the House of Representatives and the Senate not later than 10 days prior to each public notice soliciting bids related to site selection and construction, and prior to the lease or purchase of such site."

   We received OMB's concurrence on requesting expressions of interest for the data center site on August 5, 2009. We also notified all members of the Committees on Appropriations of the House of Representatives and the Senate by letter on August 6, 2009. We brief staff from the House Ways and Means Committee, Subcommittee on Social Security quarterly on the progress of the NSC project and provide monthly Recovery Act reports to the Subcommittee.

2. **Specifically, how did you reach your decision to locate the new NSC within 40 miles of the current campus? Did the GSA and the OMB also sign-off on this decision? Why or why not? The SSA's testimony referred to an advisory panel of world-class information technology (IT) experts. Did this panel sign off on the decision to locate the new NSC within a 40-mile radius of the Headquarters campus?**

   In choosing data migration technology, our primary consideration was risk mitigation. We wanted to ensure that we would successfully migrate all of the sensitive data from the National Computer Center (NCC) to the new data center without interruption of service to the public. The technology we selected decreases the risk of disrupting service. The technology works most efficiently within a 40-mile radius of the NCC. This 40-mile limitation delineated the area within which to build the new data center.

   We briefed both GSA and OMB regarding the 40-mile limit during the fall of 2008. Additionally, in May 2009, we briefed our Future Systems Technology Advisory Panel Data Center Migration Subcommittee on the new data center. We did not ask GSA, OMB, or the panel to sign-off on our decision to locate the NSC within 40 miles of the NCC.

3. **Mr. Gallagher reported at the hearing that you made the decision to locate the new NSC in a separate location from the headquarters campus. Would you explain how you reached this decision and whether the GSA and the OMB signed-off on this decision? GSA and SSA staff recently revisited the question of whether the new NSC should be located off campus after questions were raised by the staff of the Committee on Ways and Means. Why was this necessary? Didn't both agencies conduct a thorough evaluation the first time?**

   In August 2008, our staff briefed the Commissioner about options for replacing the NCC and recommended that the new data center be located off campus. In response to the Commissioner's concerns about this recommendation, staff reported that they had investigated the possibility of building a new data center on the main complex, but found that the campus had limited space suitable for a new facility. In addition, career staff recommended that building on the complex would not be the best option because of topography, parking, and residential property owned by private citizens. Most critical were concerns about the time and money it would take to mitigate these factors since the NCC's electrical system would face capacity issues as early as 2012.

   In 2009, the Commissioner convened a meeting to review options for placing the NSC on the main campus, but found no option that would not involve substantial additional costs and delay. In addition to the concerns about the current NCC's lifespan, at that time, he was concerned about any significant delays given the intent of the Recovery Act to stimulate the economy and job growth.

   GSA and OMB did not formally sign off on this decision, but GSA did not object to the preliminary drivers that we considered, which are described above.

   GSA is undertaking a comprehensive analysis of schedule, cost, and risks of an on-campus location as compared to those of an off-campus location. GSA will provide the results of the study when it is completed.

   We believe that the earlier evaluation was thorough. Nevertheless, as with any project of this magnitude, additional issues and possibilities arose as we went forward. Both we and GSA believed that these emerging issues merited additional evaluation.

4. **I was pleased to see that by January, Durham will be able to recover Social Security's critical systems from backup tapes, and that by October, Durham will be able to recover all systems. However, according to the SSA's testimony, it will take the SSA seven days to restore these systems, and the ability to synchronize data between both data centers will not be possible until close to three years from now.**

   - **Should a catastrophic failure occur, how can you ask the American people who rely on your services to wait seven days? How exactly would the SSA's operations change for the seven-day period?**

In a catastrophic loss of the NCC, our field operations would revert to non-automated means of serving the public, such as using paper forms and deferring non-time sensitive requests. Paper-based methods would protect the public from losing any potential eligibility to benefits. Treasury would still issue monthly benefit checks, and we could continue to make critical one-time payments. Non-critical workloads, however, would back up until our systems were restored.

- **Please explain why it will take close to three years to synchronize data between both centers.**

  Our IT operation is one of the largest in the Federal Government, and most of our data contains sensitive personally identifiable information. The sheer volume of our data makes synchronization and enormous challenge. We must meet the ever-growing IT demands from our customers, implement new legislation, modernize our databases, and retool our applications software. At the same time, we are changing our IT model, dividing our data between two sites. This change will result in a 700 percent improvement in our IT disaster response time, reducing the time required to fully restore our data from 7 days to 1 day.

  As our IT operations grow, it is critical that we protect the integrity of that data and safeguard it against loss or corruption. The process for migrating this amount and type of data is complex and time consuming. As we go forward, we must follow all prescribed measures to ensure that we remain fully operational while we synchronize our data. Based on best industry practices, this process will take at least three years.

  We have forecast fiscal year 2012 as the target for safely and successfully completing this challenging and complex "synchronization" effort, without disrupting service to the public. The measured progress over this three-year period can be summarized as follows:

  - In 2009, occupy the Second Support Center (SSC), divide our IT workloads, and halve our disaster exposure;
  - In 2010, synchronize workloads moved to the SSC with the NCC in Baltimore, and test our capability to recover them in 24 hours;
  - In 2011, synchronize NCC workloads in the SSC, and test our ability to recover in 24 hours in case of a disaster; and
  - In 2012, complete the testing to ensure we can recover both workloads in both centers, and begin annual testing certification processes.

5. **At the hearing, Mr. O'Carroll discussed how the Durham Support Center has progressed from its initial purpose of redundancy to becoming a secondary data site. Please provide a historical summary of the development of the Durham Support Center that includes its original purpose/function, how that has changed over time, its current status, and the plans for its future.**

From inception, we intended that the SSC would serve as a co-processing data center that would run a portion of our production work on a full-time basis. This means that the building does not sit idle waiting for a disaster; rather, it is staffed, maintained, and always ready to assume most of our IT operations in the event of a disaster. In addition, a co-processing design is efficient because there is ongoing use of the resources invested in the facility.

In 2008, the Commissioner decided to invest $20 million in the SSC to expand its capabilities to support non-critical as well as critical workloads.

The SSC opened in January 2009 and is fully operational as a major IT center, serving our IT operations 24 hours a day, 7 days a week. In May 2009, we began processing mission critical workloads at the SSC.

The SSC now contains:

- Medical images for electronic disability folders;
- Four mainframe computers;
- Billions of characters of data storage;
- Magnetic tape robots to create backup copies of critical data and provide the capability to use those copies to restore that data in the event of data corruption or data loss;
- Fully-redundant telecommunications connections to all of our offices, the Internet, and the NCC in Woodlawn, Maryland;
- A mirrored IT operations control center synchronized with the NCC; and
- A full-time staff of about 120 employees and contractors.

When we moved these workloads to the SSC, we reduced our potential data loss by 50 percent. We also improved our ability to sustain operations because the SSC supports our employees' access to:

- Our network and the Internet in all offices;
- Essential Blackberry communications services;
- E-mail (including access from the Internet);
- Connectivity to SSANet for traveling employees; and
- Our program policy web-site.

The SSC also houses one of four service delivery points for our new Voice Over Internet Protocol (VoIP) telephone system. At this time, it is the primary site for approximately 100 offices and can assume full operation of VoIP in the event of a disaster at the NCC site.

With regard to our future plans, we have strengthened the role and function of our Chief Information Officer (CIO) to ensure that we have a long-term vision, and the process is in place to make use of leading edge technology. In addition, we have established a Future Systems Technology Advisory Panel, comprised of industry experts, to advise us on the future use of technology. Both the CIO and the Panel will be instrumental in helping determine how the SSC might be expanded or modified to take account of our future technology needs.

6. **Please summarize the steps taken and planned to extend the life of the NCC, including their final or expected completion date and how these steps will extend the life of the NCC.**

We are continuing our scheduled preventive maintenance to ensure the building infrastructure systems remain fully operational through calendar year 2014, and, if necessary, longer. Following are specific examples of our activities:

- We continue to perform maintenance during the annual shutdown on Columbus Day.

- We purchased spare Uninterruptible Power Supply (UPS) parts in April 2009 and extended a service contract to ensure the UPS system remains operational through 2015.

- In May 2009, we replaced critical electrical feeders between the Utility and NCC buildings to avoid possible failure due to age and deterioration.

- We will complete our NCC riser panel project to upgrade electrical capacity in three phases by July 2010, replacing 256 electrical riser panels. We completed phase one over the 2009 Columbus Day weekend, and phase two over the 2010 President's Day weekend. Additional shutdown dates are:

  - Memorial Day weekend 2010, and
  - Independence Day weekend 2010 (if necessary).

- We will install additional UPS risers (for computer equipment) and general house power risers (for additional cooling equipment) by January 2011 when we have opportunities to shut down operations.

- We will expand the Social Security Number Card Print Room to allow for additional inserter machines by June 2010.

In 2009, we invested in projects ranging from redesigning space within the NCC to upgrading the power by adding four additional feeder cables (two for the data center and two for house power). The feeder upgrade will allow us to install an additional 80 servers in the NCC. Reconfiguration and renovations to the NCC inner core have resulted in approximately 4,000 square feet of available space for the additional server cabinets necessary to support our workloads by September 2010.

In each fiscal year, we have a placeholder for $500,000 to renovate and improve the NCC. In FY 2010, we have an additional $300,000 to establish a new Security Operation Center lab. In FY 2011, we have a placeholder for $18 million for design and construction of new air handlers if needed. We expect the existing air handlers will remain operational until 2015.

7. **How much of the Recovery Act funds provided for replacing the NCC have been expended to date and how many jobs have been created as a result?**

To date, through a Reimbursable Work Authorization, we have obligated $2,101,403 of Recovery Act funds to GSA for the NCC Replacement Project. GSA should be able to provide information about the jobs created through the project management and consulting firms hired thus far to support the planning processes.

8. **What assurances can you give our Subcommittees and the American taxpayers that the new NSC will be built on time and within budget? What is different about the management and oversight of this building that will prevent cost and deadline overruns?**

We are working closely with GSA to ensure that the new NSC will be built on time and within budget. Both agencies are taking a number of steps to ensure that we do everything possible to meet our goals. A thoughtful architectural plan will minimize the need for subsequent changes, typically the major source of cost overruns in large construction contracts.

The site location may affect the risks associated with cost and time. Nonetheless, we will continually assess the project and employ risk mitigation strategies to avoid time delays and cost overruns. A project team comprised of GSA, Jacobs (GSA's contractor), and our staff will monitor and coordinate all project work and provide weekly updates to senior executives.

We have begun efforts aimed at consolidating some of SSA's IT hardware assets currently in the NCC so that we can lessen the number and complexity of the resources that must be moved to the NSC when it is operational. However, given the planned schedules for refreshing the IT hardware in the NCC, virtually all of the equipment that is currently installed will need to be replaced before we begin our migration efforts. We will initiate detailed transition planning during FY 2012. Our IT staff gained valuable experience in the move of similar workloads to the Durham site earlier this year. This experience will be invaluable in assuring that we can accurately assess the level of effort, complexity,

prerequisites and dependencies necessary to insure that the IT migration to the NSC will be completed on schedule while minimizing risk of outage for SSA's customers and insuring that there is no loss of data.

9. **In reviewing the testimony, there are references to Jacobs Facilities, EMC Consultants, Lockheed Martin, Booz Allen Hamilton, Strategic e-Business Solutions, Uptime Institute, as well as an advisory committee of IT experts, the CIO, a GSA/SSA team of architects, electrical engineers, mechanical engineers, fire protection engineers, project managers, occupational safety and industrial hygiene experts, physical security specialists, and network and IT engineers. GSA experts in real estate and building construction and SSA experts in data center design and operations as well as seasoned SSA real estate professionals are also mentioned.**

   Allowing for the complex nature of the NSC project, the need for a wide variety of support is understandable. However, please help the Subcommittees understand how all of the pieces are working together here to achieve a completed center and ensure continued service and improvement for Social Security's programs. For instance:

   - **How many consultants and contractors have been involved in the process so far, who has hired them and what is the cost of services?**

     We hired several outside consultants to assist us in various aspects of planning for the new data center. We initiated and funded the following studies prior to receiving Recovery Act funding:

     - We hired Lockheed Martin to conduct a feasibility study that looked at the condition of the NCC and determined the need for a new data center. Lockheed Martin was involved in the project in 2007-2008. The cost of this study was $530,714.

     - Booz Allen Hamilton issued the SSA NCC Alternatives Analysis dated February 18, 2009. This was a life-cycle cost analysis of the proposed viable options contained in the Lockheed Martin study. We contracted for this study to support the IT capital asset and performance-tracking information (also known as the "Exhibit 300 Report") submitted to OMB. The cost of this study was $10,000.

     - Booz Allen Hamilton also conducted an SSA Distance Sensitivity Study for the New SSA Data Center and issued its report on April 20, 2009. This study analyzed the life cycle cost of the new data center at differing distances from the headquarters campus. The cost of this study was $136,000.

     As previously mentioned, we submitted $2.1 million in Recovery Act funds to GSA. GSA should be able to provide specific information about the contractors hired so far to support the project.

     The Social Security Office of the Inspector General (OIG) also hired a contractor, Strategic

e-Business Solutions, to assist in oversight activities of this project. OIG should be able to provide specific information about its contractor.

- **How are the results of their work coordinated and who is in charge of that coordination?**

  A project team comprised of GSA, Jacobs (GSA's contractor), and our staff coordinates all project work. GSA's project executive leads the joint project team. The staff subject matter experts on the joint project team meet no less than weekly and provide weekly update meetings to senior executives. While much of the day to day coordination occurs through the ongoing work of the project team, our Associate Commissioner for Facilities Management leads our effort.

- **How can we assure our constituents that their hard-earned taxpayer dollars are being used effectively and that Social Security benefits they depend on will keep arriving on time?**

  Through the ongoing monitoring process, our senior executives provide oversight to the new data center project and ensure good stewardship of taxpayer dollars. Both our staff and GSA staff brief staff from the House Ways and Means Committee, Subcommittee on Social Security quarterly, and provide monthly Recovery Act reports to the Subcommittee. To ensure transparency, we routinely update the recovery.gov website with project status information, and our CIO is establishing an agency website to keep the public informed of activities related to the new data center.

  In addition, OIG received $2 million for oversight and audit of programs, projects, and activities funded with Recovery Act funds. To date, OIG has completed or is conducting the following reviews related to the new data center:

  - Quick Response Evaluation: The Social Security Administration's Ability to Address Future Processing Requirements - Final report received March 16, 2009;

  - Quick Response Evaluation: The Social Security Administration's Disaster Recovery Process - Final report received June 5, 2009;

  - OIG Quick Response Evaluation: The Social Security Administration's Use of Site Selection Industry Best Practices for its New Data Center;

  - OIG Congressional Response Report: The Social Security Administration's Data Center Alternatives;

  - OIG Review: The Social Security Administration's Use of Data Center Industry Best Practices in its National Computer Center Replacement Strategy Under the American Recovery and Reinvestment Act;

- OIG Quick Response Evaluation: The Social Security Administration's Disaster Preparedness.

SOCIAL SECURITY

The Commissioner

June 25, 2010

The Honorable Earl Pomeroy
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your May 11, 2010, letter requesting additional information to complete the record for the hearing on our ability to meet our growing workloads and serve the public through our field offices, teleservice centers, and the Internet. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

/s/

Michael J. Astrue

Enclosure

cc: Kathryn Olson, Majority Staff Director, Subcommittee on Social Security of the House Committee on Ways and Means

Questions for the Record from Chairman Pomeroy Subsequent to the April 15, 2010 Hearing before the House Committee on Ways and Means Subcommittee on Social Security

1. **The witnesses for the American Federation of Government Employees complained that a directive to field office staff to forgo the "break-even" discussion with claimants could result in choices made that may prove "disadvantageous" to claimants.**

   a. **What information do claims representatives give to ensure that applicants understand the differences in their monthly benefit amount if they claim earlier rather than later?**

   We provide claimants with information about the amount of their unreduced benefits payable as well as the monthly amounts they would receive if they chose to take benefits earlier or later. Online filers are provided the same information and can get benefit estimates by using the link to the Retirement Estimator included in the application path. We provide claimants with information about known factors that may affect the month-of-election decision, such as the amount of earnings from work or self-employment, the effect of non-work months, protective filing, and retroactivity. Claims technicians also explain the concepts of reduced retirement benefits and delayed retirement credits including the effect of receiving retirement benefits on their survivors' benefits. All of this information is also available to claimants who file online.

   Most claimants, however, cannot afford to wait to collect their benefits. Over one-half of claimants take retirement at the earliest time possible. Some private retirement pensions require that choice, while some workers do not have the financial means to make a different choice.

   Because when to start receiving benefits is a personal decision, our claims technicians should not attempt to influence the claimants' decision. The role of the technician is to provide social security program information rather than to weigh-in on the claimants' benefit decisions or provide financial planning advice. We have attached our policy instructions at A, and they can be found at http://policynet.ba.ssa.gov/poms.nsf/lnx/0200204039.

   b. **Why has SSA de-emphasized the "break-even" discussion with claimants?**

   Life expectancy continues to rise and the full retirement age has increased over time. Beneficiaries are likely to be retired for a longer period, and so the question of when they will "break-even" is less important than ensuring that they will have adequate resources available during their retirement years. It is an over-simplification to assume that consideration of the "break-even" point will result in the most advantageous month of election. In addition, focusing a benefit discussion on the break-even point may unduly influence claimants to retire early, which depending on individual or family needs, may not be in their best interests. We have updated our policies to ensure that while we discuss all known factors that affect benefits amounts, we do not influence a claimant's

decision about when to begin receiving benefits.

If during a discussion of benefit options, a claimant requests break-even computations, we will provide them, answer any questions, and emphasize that they should consider a variety of factors when making a decision about when to take benefits.

c. Given the concerns expressed by SSA employees, has SSA taken any steps to explain the directive so that field staff better understand the purpose for this directive? Is their concern an indication that field staff lack sufficient training to fully comprehend the issues involved in the decision of when to retire?

When we revised our policy regarding month-of-election discussions in late 2008, we provided training to all claims technicians. Since then, we have provided training updates on the revised policy through supplemental training and written instructions and have clarified instructions during regular management discussions.

While our policy provides for a broad discussion about retirement, given the many factors that a claimant must consider, we do not attempt to lead the claimant toward any specific month-of-election choice.

Our employees are not trained to offer financial advice, and we do not want a policy that places them in a position to have to do so. Rather, we provide information to the public that they can use when making their retirement decisions. In addition, we now provide age-appropriate information regarding Social Security to all workers and former workers aged 25 and older, through inserts to the *Social Security Statement (Statement)*. Our field offices also offer a new factsheet entitled "When to Start Receiving Retirement Benefits."

d. Is it true that SSA employees are directed to avoid a discussion altogether about a claimants' decision on when to retire unless the claimant asks explicitly for advice?

No, as explained in our response to Question 1. a. above, our employees are instructed to discuss the claimant's benefit election options. Our technicians provide information about the kinds of benefits for which a claimant may be eligible, as well as options regarding when he or she may want to begin receiving these benefits, including the break-even point if the claimant asks. Our goal is to inform, but not influence, the decision.

2. The witness for the Government Accountability Office (GAO) noted that a significant number of upcoming retirements will be from the ranks of SSA's supervisory staff, who are among the agency's most experienced staff. She also said that it would take years to replace the "...decades of knowledge that will be lost from these retirements" and that SSA will likely experience declines in productivity as new staff replaces those with more experience.

a. Does SSA rely only on mentoring to prevent the loss of institutional knowledge that could occur as SSA transitions from a workforce with many experienced employees to one with newer, less experienced staff? If so, how has SSA reacted to the reduced

ability of experienced employees to mentor given their need to handle other time-consuming workloads?

Mentoring is a valuable tool that we use to help mitigate the loss of institutional knowledge. The importance of mentoring is deeply ingrained in our culture. We assign mentors to both newly hired and recently promoted employees in field offices, processing centers, and teleservice centers. Mentors work with their assigned trainees on a daily basis--coaching, answering technical questions, and providing the trainees with feedback on the quality of their work.

Mentoring, though, is not the only strategy we use to minimize the loss of institutional knowledge. For example, we have taken advantage of the hiring authority to reemploy experienced retired annuitants to work with our newer employees and managers and to fill knowledge gaps lost through retirements. The Voluntary Early Retirement Authority (VERA) granted by the Office of Personnel Management (OPM) helps to spread out the time span over which our most experienced employees retire. Early-outs allow us to gradually hire new employees who will develop the necessary skills and experience under the mentoring of seasoned employees.

We also have a robust training program, including videos on demand covering a wide variety of topics that employees can watch in training centers or at their desks. We are currently reevaluating our entry-level training to determine if we could make it more efficient and effective.

b. Specifically, what steps is SSA taking to make sure newer employees are ready to assume more responsibility as their more experienced co-workers retire?

Nevertheless, many years of underfunding have resulted in a gap in our hiring, which created an unnatural break in our employee pool. Significant hiring gaps make it difficult to maintain a steady pipeline of employees who are prepared to assume greater responsibilities and ease the transition as employees retire. We have used the funding we received in recent years to hire a significant number of new employees, and we hope to receive funding that allows us to continue to hire and train enough employees to create a steady workforce.

With respect to leadership succession, in 1997, we established a strategy for leadership development in anticipation of future management and executive-level retirements. We initiated a three-tiered approach for leadership development -- the Senior Executive Service Candidate Development Program (SES CDP), the Advanced Leadership Program, and the Leadership Development Program. In order to expand our talent pool, we recently opened up our SES CDP program to GS-14s who demonstrate leadership potential. We use mentoring, developmental assignments, and leadership competency training to create a cadre of experienced employees who will be prepared to fill future leadership vacancies. To date, we have graduated about 700 participants from our three leadership developmental programs, and the majority of our graduates have assumed higher-level agency positions. We project that as more executives and managers retire, many of the remaining graduates will also take on leadership roles.

We also created a national curriculum of leadership training for new and experienced supervisors, managers, and management staff. We designed the curriculum, entitled "Transition to Leadership," to train managers on our critical leadership competencies. Our curriculum blends formal classroom training, Interactive Video-Teletraining (IVT), workstation video training, National Leadership Symposiums, and SSA Learn leadership courses to ensure that all levels of management receive the training needed to establish and enhance leadership abilities. Subject matter experts present the majority of the introductory supervisory courses. We continually update the content of our training courses to reflect the most current policies and procedures and tailor the courses to the requirements of specific positions.

c. **Does SSA agree with GAO that there may be productivity declines as SSA's newer employees gain experience and knowledge? What is SSA doing to minimize these declines?**

While our productivity has steadily increased, our projections indicate that a significant number of front-line employees, including supervisors, will retire each year for the next few years. This loss of experienced staff could lead to a possible decline in longer-term productivity. While we have taken advantage of recent funding increases to aggressively hire, it will take time for these new employees to become fully conversant in our programs. We rely on strategic planning, developmental programs, mentoring, and training to help address the challenges we face in staff losses.

With regard to the loss of supervisors, as we describe in the answer above, we have a proven multi-tiered succession management plan.

3. **For many years, GAO has recommended that SSA develop a service delivery plan that explains how it will deliver quality service while managing growing workload demands. At the hearing, you indicated that this was a "routine" GAO request and that SSA could "get close" but was not able to comply fully with GAO's recommendation. In GAO's January 2009 report, it was reported that SSA would provide GAO with a single document that describes SSA's various service delivery and staffing plans. When will SSA complete this document? Please provide a copy to the Subcommittee.**

Our Chief Information Officer has lead responsibility to develop a new comprehensive Agency Strategic Plan that will include service delivery and staffing initiatives in addition to the issues that GAO addressed in its January 2009 audit report. We expect to publish our new plan in early calendar 2011, and we will provide a copy to the Subcommittee.

4. **I understand that it takes extensive classroom and on-the-job training before SSA employees are able to understand Social Security programs with enough expertise to effectively assist claimants. How can all this training possibly translate into the information SSA provides to claimants on the internet when they apply online?**

This question is comparing the front-end application process, in which the claimant actually completes and files an application, to the back-end adjudication process, in which our employees decide the claim. For decades, claimants have completed paper benefit applications and submitted them for our employees to review and adjudicate. The online

application has significantly improved upon the paper application process and offers a convenient, efficient service option for claimants who do not want to come into a field office. Regardless of how a claim is filed—in the office, by phone, or online—our claims technicians review all claims and contact the claimant if there are any questions.

Claimants applying for benefits through iClaim are focused on their specific situation, not on the complexities of what our employees do with that information. We provide the online filing applicant with the information necessary to file his or her claim, along with relevant information about other potential benefits.

Claimants who choose to file for benefits online have the opportunity to learn more about our programs through direct links within the online application. For example, when choosing when to begin receiving benefits, there is a link to information on our website that explains the many factors that a claimant should consider in making that choice.

Our website offers publications, retirement estimators, and links to other financial tools that explain factors to consider before making a decision about applying for Social Security benefits.

a. Does SSA evaluate the differences in the quality of decision-making between in-person (or telephone) and online applicants, especially with regard to the level of understanding claimants have about when to retire, whether to take benefits based on their own earnings or those of a spouse, ex-spouse, or deceased spouse?

We do not evaluate the quality of claimants' decision-making; however we review all claims prior to adjudication and resolve any inconsistencies or questions.

b. If so, how is this evaluation conducted? Is it done before or after the online claim is reviewed by a claims representative?

See our responses above.

5. The Commissioner testified that the accuracy rate for internet claims is the same, if not better, than that of claims taken via other methods. If true, this may be because these claims get a thorough review prior to adjudication and evaluation for accuracy.

a. Are online claims more accurate than in-person claims prior to review?

We conduct all of our quality reviews after adjudication because of the logistical difficulties in conducting in-line reviews and because reviewing claims prior to adjudication would cause delay for claimants.

We know the payment accuracy rate for iClaims is high because we evaluate all types of claims (in-office, telephone, and Internet) at the same point--after adjudication-- using the same standards, through our Transaction Accuracy Review (TAR) process. According to the TAR, our overall accuracy rates for all means of processing are 99.38 percent for

overpayments and 97.98 percent for underpayments. The overpayment accuracy rate for Internet claims is about the same (99.81 percent). The underpayment dollar accuracy rate for Internet claims (99.42 percent) is better as compared to the overall underpayment dollar accuracy rate (97.98 percent).

b. Are there aspects of the online claims-taking process that aren't captured in the Agency's accuracy rate?

No, we use the same review standard for accuracy for all claims, regardless of how they are filed.

c. Prior to review and/or re-contact by a claim representative, does SSA conduct any evaluation of the quality of claims to understand the typical mistakes or ill-informed decision-making made by online claimants regarding, for example, when to retire or whether it is more advantageous to retire on one's own earnings record or a spouse's?

No, we conduct quality reviews after adjudication.

d. In your view, is SSA sufficiently tracking and evaluating typical claimant mistakes and using this information to improve the online applications?

Yes, we regularly upgrade our Internet claims software to improve systems logic and the online application experience. Our goal is to continuously improve the clarity of information provided to our claimants, facilitating their ability to make the best choices for their individual situations. For example, a May 2009 release permitted the system to consider work and earnings in determining and providing possible month-of-election choices. In February 2010, we enhanced the iClaim application to recognize month-of-election options for those beneficiaries born on the first day of the month.

e. What is the difference in the average amount of time taken to review and approve an online claim versus a traditionally filed claim? How long does it take individual claimants to complete an online claim? Please indicate the source for this data.

Based on a recent study conducted by the Office of Quality Performance, it took claimants 37 minutes on average to complete a non-Internet retirement claim, while it took, on average, 25 minutes for a claimant to complete a retirement claim over the Internet. The same study found that filing a non-Internet disability claim took an average of 67 minutes. Disability claims filed via Internet took an average of 46 minutes.

In FY 2009, we conducted an in-depth survey about satisfaction with online filing. We asked retirement applicants how much time they spent completing an iClaim application. The majority of survey responders, 59 percent, reported that they had completed the iClaim in 30 minutes or less, 30 percent reported that it took up to an hour, and the remaining 11 percent said they spent more than an hour. Satisfaction with these time frames remained high regardless of the actual time spent on the iClaim. At the 30 minute and one hour marks, 98 percent of responders rated the time spent as excellent, very

good, or good. The satisfaction rating declined when the time spent was over an hour, but was still very positive, at 92 percent.

f. Where errors are found by claims representatives reviewing online claims, are the reasons for these errors evaluated and used to improve the online application?

Yes, we continually review employee feedback to identify additional enhancements or clarifications that could improve our online claims application. We also get feedback from the American Customer Index survey, which appears randomly to iClaim users during their online experience. We pay close attention to the responses to the open-ended questions in this survey to improve the quality of our online applications.

6. Spending on SSA's financial literacy initiatives will reach $22 million in FY 2011.

a. Did SSA conduct any analysis about how using this money for this purpose would divert from SSA's core responsibilities? For example, how many more field staff would SSA be able to hire with $22 million? How many disability appeals hearings could be conducted with $22 million?

Funding for financial literacy research does not divert resources from our core responsibilities. The $22 million request is part of the research budget within the Supplemental Security Income appropriation. Our core workloads are funded by the separate Limitation on Administrative Expenses (LAE) appropriation. Once funds are appropriated, we do not have the authority to redirect resources budgeted for financial literacy to process work.

Based on FY 2011 average agency salary and benefit rates, an additional $22 million would fund about 220 employees for one year or approximately 12,300 hearings.

b. In your testimony before the Committee on Appropriations you suggested that the project is intended to "support...the goals of the national interagency Financial Literacy Education Commission" (FLEC) which is coordinated by the Department of the Treasury. Chairman Obey stated that while Congress had established the Treasury initiative and appropriated funds for this project, there was no similar directive from Congress that SSA carry out similar activities. During questioning you indicated that Treasury had asked SSA to conduct this research and development of financial literacy education materials. Please provide the Subcommittee with written evidence of a specific request by Treasury for SSA to carry out this initiative, and the date of this request.

In responding to Chairman Obey's questions, I merely stated that "[m]ost of the additional work that we've been doing has been to support administrative initiatives in the area of promoting savings and financial literacy." It is my understanding that OMB carefully reviewed our plans in our budget submission, including our participation in the Financial Literacy Education Council (FLEC). The FLEC coordinates financial education efforts throughout the Federal Government. Though FLEC coordinates financial literacy activities across member agencies, the member agencies conduct the activities. We are developing our financial literacy projects as part of FLEC's ongoing

activities.

We are collaborating with FLEC in developing our financial literacy projects and have been an active member of the commission. For example, we are leading an effort to survey FLEC agencies about research and development objectives to develop multi-agency collaborative research projects to support an evidence base for financial literacy interventions across FLEC agencies. Additionally, we are chairing or co-chairing three of the four standing FLEC working groups: National Strategy; Research and Evaluation; and Communication and Outreach.

c. Did SSA conduct any analysis or coordinate its plans for this initiative with the Administration to ensure that SSA's scarce resources would not be used to duplicate the many efforts that are already being undertaken by the Treasury Department and in the private sector? What specifically did SSA learn about similar financial literacy activities undertaken by other entities that led to the conclusion that SSA needed to fund further research and development in this area?

We included a description of our initiative in both our most recent Agency Strategic Plan and Congressional Budget Justification. We explained that we were launching a research initiative to better inform the public about retirement planning options. Our Budget Justification also included a request for funds to support our activities with FLEC. As part of our involvement with the FLEC, we made Treasury and other participating governmental entities aware of the details of our funded projects.

To obtain input from the private sector, we consulted experts in the field of retirement policy, who indicated that many products and programs designed to change savings behavior are developed and implemented without evidence-based evaluation. They agreed that a key objective should be to use research to develop programs and products to improve retirement planning and then to rigorously evaluate them. Our research efforts include evidence-based evaluations. We have made this information available to the public. All of our funded project abstracts are available on the Internet, at: http://www.ssa.gov/retirementpolicy/abstracts.html.

d. Please describe in detail the process by which SSA decided to whom to award grants under this initiative as well as any confidentiality agreements between SSA and advisory panel members concerning restrictions on their ability to discuss their work outside the panel.

In April 2009, we published a Request for Applications (RFA) for research proposals that would address our financial literacy objectives. The Financial Literacy Research Consortium (FLRC) is the result of this open competition that awarded funding for 26 research projects. The review process for selecting projects proceeded in three stages: elimination of nonresponsive applications, expert panel review, and administrative review.

The first step of the review excluded applications that were not responsive to the call for research and development in the RFA.

At the second stage, we convened an expert panel to review the applications. The panel was very diverse with respect to expertise, personal demographics, and organizational representation and outlook. We vetted the panel to ensure against conflicts of interest that would preclude members from reviewing any or all of the applications. We informed the panel that all applications and review discussions were confidential and could not be shared or discussed with any other persons. This confidentiality protected both the applicants' ideas and the reviewers' critiques.

The final step of the awards process was an administrative review. After considering all of the elements of the review process for establishing the FLRC, agency staff made awards to Boston College, the RAND Corporation, and the University of Wisconsin-Madison. The principle investigators of the centers are leading experts in the fields of financial literacy and retirement research.

While we instructed reviewers not to discuss details of specific applications, panel members did not have to sign confidentiality agreements, primarily because such agreements would not be enforceable. However, the agency official responsible for conducting the grant application technical evaluation specifically informed the panel that their comments and ratings were to be kept confidential.

e. **Did the advisory panel raise any concerns about the initiative overall or the particular proposals? Please provide separately to the Subcommittee (not for publication in the record) any communications to SSA from the advisory panel or its members.**

Yes, some members of the panel had concerns about the grant proposals and the scope of the request for applications. I was not the award decision maker and was not informed about these concerns until very recently. When I became aware of them, I directed staff to closely monitor the FLRC's progress.

The design of the FLRC allows us to evaluate progress on an ongoing basis, and if necessary, to end funding even after the initial award is made. The FLRC has mechanisms to ensure that work is innovative, relevant to our initiative, and not duplicative of other efforts. These ongoing review mechanisms include quarterly progress reviews conducted by program and grant management staff, a twice-a-year review of activities by our expert panel of outside scholars, a public annual conference, and interaction with other Federal agencies regarding research program development. We will carefully evaluate the FLRC's progress before funding additional work. We will review the FLRC and Retirement Research Consortium programs to identify and, if appropriate, eliminate any overlap. We are providing a copy of the note in which some panel members raised concerns. We have redacted the members' names and language that would infringe on the members' confidentiality expectations.

7. **In the description of SSA's "Special Initiative to Encourage Savings," the claim is made that "only 18 percent of workers can correctly identify the age at which they will be eligible for full Social Security retirement benefits."**

a. Does SSA know how many Americans understand the impact on their monthly benefit amount if they file for early retirement benefits, if they file on their own earnings instead of a spouse's record, or if they file when working?

In a 2007 survey, the Employee Benefits Research Institute (EBRI) asked workers to identify the age they believed they would be eligible for unreduced Social Security benefits; i.e., their full retirement age. EBRI reported that more than half of all workers surveyed underestimate the age, 7 percent overestimate the age, 20 percent state they do not know, and 19 percent give their correct full retirement age. The analysts noted that older workers (aged 55+) are more than twice as likely to respond correctly compared to younger workers. Further, EBRI reported that these statistics have been rather stable since they first started asking the question on the annual RCS in 2000. The survey results summary is available online at http://www.ebri.org/surveys/rcs/.

While we do not know how many Americans understand the implications of filing for benefits before full retirement age, we provide two tools specifically designed to enhance the public's understanding of benefits and to support retirement planning—the *Social Security Statement (Statement)* and the online Retirement Estimator.

- *The Social Security Statement* (http://www.socialsecurity.gov/mystatement/) provides personalized information about Social Security retirement, spousal, survivor, and disability benefits based on a worker's lifetime earnings. The Social Security Act requires that we mail a *Statement* to workers and former workers aged 25 and older and workers of any age who request it. We mail *Statements* to about 150 million Americans a year.

  We made two improvements to the *Statement* in 2009. First, we reformatted the *Statement* to show, in the most prominent position, the amount of benefits a worker could expect at full retirement age. The prior version of the *Statement* listed benefit information for early retirement first. Second, *Statement* mailings now include a customized insert, one to workers 25-35 years old focusing on saving for the future and a second to workers 55 and older focusing on benefit choices for near-retirees. (http://www.socialsecurity.gov/mystatement/statsamples.htm)

- The Retirement Estimator (http://www.socialsecurity.gov/estimator/) is an online tool that produces personalized estimates of Social Security retirement benefits, based on a worker's actual Social Security earnings records. The estimator provides benefit data for different retirement ages so that workers can better formulate adequate retirement plans.

b. How much in dollars and percentage of financial literacy initiative spending is focused toward improvement of workers' understanding of Social Security retirement age issues? What improvement in data does SSA expect to achieve, and how will this be measured?

During FY 2009, approximately $74 million of the $80 million (around 92 percent) of total financial literacy spending went toward improving workers' understanding of Social

Security retirement age issues, including approximately $69 million to fund the statutorily mandated *Social Security Statement*, $500,000 for the Retirement Estimator, and approximately $4 million for retirement age research. The remaining $6 million was used for research not related to retirement age issues.

We agree that it is important to be able to measure improvement in workers' understanding of Social Security retirement age issues, and we are examining the best methods for capturing this information.

c. **If only 18 percent of Americans know their full retirement age, why is it a valid assumption that American workers sufficiently understand how to make a correct decision on the benefits application simply by reading a page on the internet? Aren't the interactions between age at retirement, dual-entitlement rules, and the effect of work on an entitlement to benefits rather complex?**

The process for filing an online retirement application is relatively straight forward. At the time of filing, we provide applicants with information to help them make the best decision. Claimants who choose to file for retirement online have the opportunity to learn more about our programs through direct links from the online application. For example, when choosing the best month to begin to receive benefits, the link to our website explains that there is no "best age" to retire and that many factors should be considered in making that choice. We provide a full explanation of these factors to guide our online claimants in making their decision.

The public also has access to our publications, retirement estimators, and financial tools on our website that explain factors to consider before making a decision about applying for Social Security benefits. In addition, before adjudication, claims technicians review all claims, whether filed in the office, by phone, or online, and contact the claimant if there are any questions.

We agree, however, that all Americans could benefit from a greater understanding of their retirement situation and benefit options. Regardless of service delivery channels, research shows that there has been a longstanding gap in knowledge about the Social Security program. This finding supports the need for financial literacy initiatives. Our research program is actively working toward answering questions about how to inform Americans about both Social Security and the importance of retirement planning.

Attachment

Effective Dates: 05/13/2009 - Present (Go to History)

TN 71 (11-08)

GN 00204.039 Explaining Month of Election (MOE)Options

A. Introduction

When to start receiving benefits is a highly personal and important decision that determines the amount of benefits that the claimant will receive for the rest of his or her life. The claimant will likely consider many different personal factors when making this decision.

Social Security offers information about benefits to the claimants by mailing social security earnings statements, developing agency publications, and providing information and calculators for estimating benefits on social security's internet site.

This policy helps the technician (claims representative or other SSA employee conducting the claims interviewer) determine what information can be provided during the interview to help the claimant make informed decisions on when to begin receiving benefits.

B. Policy

The role of the technician is to provide social security program information and not attempt to persuade the claimant about benefit decisions.

During the claims interview, the technician should screen the claimant to determine eligibility for benefits. Social security program information presented during the interview is based on the following:

- Benefits for which the claimant may be eligible.
- Applicability of information to the claimant's situation.
- Information requested by the claimant.

NOTE: When a claimant decides on a MOE, the technician should accept that decision.

C. Procedure to explain MOE options

The interviewing technician should not focus on breakeven points, which is when the total benefits received during a lifetime would be equal if comparing two different MOE. The use of breakeven points is no longer applicable because of changes in life expectancy. Also, this approach does not consider many personal factors that the claimant may need to evaluate when making benefit decisions. The preferred explanation of when to elect benefits should entail the monthly benefit amounts (MBA)s for different start months and other information related to the claimant's filing situation.

If breakeven points are requested, the technician should calculate them, answer the questions, and emphasize the many significant factors that should be considered when making a MOE decision.

The interviewing technician should provide the following information during the claims interview when applicable to the claimant's MOE decision process. This information is not required if the claimant has already decided when to begin receiving benefits. If the claim is filed in iClaim, contact may be required for clarification purposes. . See GN 00204.055J. for iClaim procedures.

1. Determine monthly benefit amount for different months of election

The technician should:

- Determine the MBA based on different MOE.
- Provide MBA for the earliest possible MOE, at full-retirement age (FRA) if later than the earliest possible month, and at age 70.
- Provide MBA for any other months requested by the claimant.

Consider protective filing and retroactivity when determining the earliest possible MOE (see GN 00204.010).

Inform the claimant that entitlement to benefits affects all future payments to him or her unless the claim is withdrawn (see GN 00206.000).

a. Delay starting retirement benefits (RIB) after Age 62

The technician will explain how the MBA is higher for each month that benefits are delayed after age 62 and are reduced for age prior to FRA. (See RS 00615.000.)

b. Delayed retirement credits (DRCs)

The technician will explain how delaying retirement until after FRA will result in a higher MBA due to the accumulation of DRCs up to age 70 (See RS 00615.690).

2. Explain how earnings may change the MBA

a. Annual earnings test AET and adjustments at FRA

The technician wll:

1. Review the earnings record (ER) with the claimant per GN 01010.011.
2. Explain that he or she are allowed to earn an annual exempt amount and still receive benefits. (See RS 02501.000)
3. Explain that after reaching FRA he or she can work, earn as much as he or she wants, and still receive full RIB. (See RS 02501.021.)
4. Explain that in the year the monthly earnings test applies, benefits will be paid for any MOE in which the claimant does not earn wages of more than the monthly exempt amount and does not perform substantial services in self-employment (see RS 02505.065), even if the total earnings are in excess of the annual limit. See RS 02501.030 for more information concerning the monthly earnings test.
5. Explain how the MBA will be increased at FRA for any months they didn't receive a benefit payment because of work. (See RS 00615.480)
6. Explain how auxiliaries affect the charging-off of excess earnings; and eligibility for other types of benefits for the claimant and auxiliaries (e.g. children, spouse, and divorced spouse). (See RS 02501.095B)

b. Effect of additional earnings on the benefit computation

The technician will explain how additional earnings after beginning to receive RIB, could increase the

MBA based on the averaging of the highest 35 years of earnings.

3. Explain Auxiliary and Survivor Benefits

The technician will explain:

- the effect of the MOE on auxiliary and survivor benefits.
- that entitlement to a reduced benefit (whether received or not) will result in a Retirement Insurance Benefit limitation (RIB LIM) being placed on a subsequent widow(er)'s insurance benefit (WIB) amount (see RS 00615.320).
- that RIB can be voluntarily suspended to earn DRCs even while the auxiliaries are receiving benefits. (See GN 02409.100 - GN 02409.130)
- that a claimant who attains FRA,--when deemed filing does NOT apply,--may elect to receive only spouse's benefits and continue accruing DRCs on his or her own social security record. The claimant may then file for RIB at a later date and receive a higher MBA based on the effect of DRCs. This is possible because a claimant may choose to limit or restrict the scope of the application to exclude a class of benefits. (See GN 00204.004 and GN 00204.020)
  NOTE: If a claimant elects not to restrict benefits on his or her own record but instead is awarded with benefits suspended, the MBA as a spouse will be lower (i.e., only the larger excess monthly benefit amount (LEMBA) will be payable).
- that, if the claimant's spouse is receiving or will receive a government pension based on non-covered earnings, the government pension offset (GPO) may apply to the spouse's benefit. (See GN 02608.000)
- if a potential claimant has a spouse who is eligible for unreduced benefits or children who could qualify on the ER, explain to the claimant that additional benefits are payable to the auxiliaries, and that a possible loss of benefits can occur if filing is delayed. Explain that benefits payable to auxiliaries will not be reduced because the claimant is receiving or has received reduced benefits.
- if applicable, how children may be eligible for benefits. (See RS 00203.001)

4. Dual Entitlement (DE)

It is possible for a claimant to be eligible for:

- Two reduced benefits or
- An unreduced benefit and a reduced RIB or WIB

If the claimant is eligible to two reduced benefits, explain how their claim is processed for DE.

If the claimant is entitled to both an unreduced benefit and a reduced benefit, explain the amounts payable on each SSN and the effect of DRCs, if pertinent. Explain the effect of DRCs to a claimant who has reached FRA and is eligible for RIB. Since benefits are actuarially fair in general, explain to the claimant that he or she might consider receiving the smaller benefit first and preserving the larger benefit for the future. However, it must be the claimant's decision.

A widow(er) is not required to be FRA to be eligible for a WIB increase based on the deceased claimant's DRCs. Always explain the amount of future benefits payable, as well as the amount of current benefits payable, to help the claimant make an informed choice. Please refer to GN 00204.045 pertaining to RIB LIM situations and the discussion of the highest benefit month. Also, see #6 in this section when a claimant is a fully insured survivor.

NOTE: The field office or processing center will review the certificate of election for widow(er)'s benefits (SSA-4111). If RIB LIM is involved, the claimant may be re-contacted if he or she selects a month that does not maximize the benefit amount. (See RS 00207.025 and GN 00204.045)

5. Disability involvement

If the claimant is not insured for Disability Insurance Benefit (DIB) but is eligible for WIB and a higher RIB, discuss possible entitlement to Medicare as a disabled widow(er) since a disabled widow(er) may receive Medicare before age 65. Refer to RS 00207.020 concerning HI benefits for the disabled widow (er).

NOTE: If the claimant is insured for DIB and auxiliaries are involved, discuss the different RIB and DIB family maximums.

6. When the claimant is eligible to survivors benefits and RIB

A fully insured widow(er) has several options such as WIB first and RIB at FRA or at age 70 when he or she may receive DRCs. Explain all options so the claimant can make an informed decision. RS 00615.160 explains the computation of RIB after WIB.

7. Supplemental security income (SSI) is involve

If the claimant is eligible to receive or is already receiving SSI payments, the earliest MOE must be selected. (See SI 00510.001D. for the rules governing filing for Title II benefits when SSI is involved)

8. Medicare Involvement

If the claimant delays the start of RIB until after age 65, he or she may still file for Medicare but will be responsible for Medicare premium payments.

9. Mention personal factors that one might consider when unsure about when to begin receiving RIB.

You may mention the following personal factors that one might consider. However, you should not provide any advice concerning these factors.

- The decision about when to begin receiving RIB is a personal one and there is no "right" answer for everyone.
- MBA vary depending on when they start.
- The number of years during one's retirement might be substantial. One should consider financial needs now vs. later retirement years.
- The effect of the RIB LIM and DRCs, and, how they affect WIB benefits.
- Benefits for eligible spouses and children.
- How earnings from continuing to work may affect RIB.
- There is a chance that one can live long past the "average" life expectancy.

10. Examples to show a claimant when he or she insists on a breakeven calculation

a. On July 3, 2008, Jane Smith whose date of birth is June 15, 1946 inquires about filing for WIB. Her deceased husband received RIB and the RIB LIM of $700.00 is the highest possible WIB. She is also insured for RIB with a PIA of $1000.00. Mrs. Smith is undecided on which record she should apply. She asks the technician to explain her options. She wants to know if she waits until age 70 to file for RIB how long she would have to live to recover the money not received by waiting.

   Option 1: Mrs. Smith can elect WIB benefits of $700.00 effective July 2008 and file for RIB at age 70 with a monthly benefit amount of $1320.00 (DRCs included).

Option 2: Mrs. Smith can elect reduced RIB effective July 2008 and receive a monthly benefit of $754.10 from July 2008 continuing.

OIA-(Option with initial advantage) is OPT 2
OIA Exceeded in March 2017

OPT1 TOT BEN = $79,700.00 8 years, 9 months

OPT2 TOT BEN = $78,170.00 8 years, 9 months

No future breakeven date

The technician will explain these options to Mrs. Smith and give her the breakeven of 8 years and 9 months. The technician will also explain to Mrs. Smith that there are many other factors to consider such as financial need now versus later retirement years. Her WIB will not increase but her own RIB benefits will grow considerably.

b. Jay Crew comes into the office on July 17, 2008, inquiring about RIB. His date of birth is July 25, 1946. He is no longer working and is undecided on when to begin receiving his benefits. He is married and his wife is 60 years old. There are no eligible children. He has his annual earnings statement with him and asks the technician for an explanation of the different amounts. He is considering waiting until age 70 but he wants to know if that is to his advantage. Mr. Crew's PIA is $1000.00 and his age 62 amount is $754.10 with $1320.00 at age 70.

OIA is OPT1
OIA Exceeded in January 2027

OPT1 TOT BEN = $167,388.00 18 years, 6 months

OPT2 TOT BEN = $167,640.00 10 years, 7months

No future breakeven date

The technician would explain to Mr. Crew about the increase in his MBA due to earning DRC. Mr. Crew will also be informed about how DRC could benefit his spouse. Also, explain to Mr. Crew that he should consider his financial needs now versus later retirement years and that there is no "right" answer for everyone.

Section History

Go To Transmittal or Action Item Explanation

Prior Versions of Section

Effective Date	Title
11/05/2008 - 05/12/2009	Explaining Month of Election Options
10/23/2006 - 11/04/2008	Explaining Reduced Benefits -- Title II
09/26/2005 - 10/22/2006	Explaining Reduced Benefits -- Title II
09/27/2000 - 09/25/2005	Explaining Reduced Benefits -- Title II
12/10/1998 - 09/26/2000	Explaining Reduced Benefits - Title II

Link to this section:
http://policynet.ba.ssa.gov/poms.nsf/lnx/0200204039

GN 00204.039 - Explaining Month of Election (MOE)Options
Batch run: 10/21/2009
Rev: 05/13/2009

SOCIAL SECURITY

The Commissioner

July 28, 2010

The Honorable Sam Johnson
Ranking Member, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Johnson:

Thank you for your May 20, 2010 letter requesting additional information to complete the record for the hearing on our field office service delivery. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

/s/

Michael J. Astrue

Enclosure

cc: Kim Hildred, Staff Director, Subcommittee on Social Security of the House Committee on Ways and Means

Congressman Sam Johnson's Questions for the Record Subsequent to the April 15, 2010 Hearing Before the House Committee on Ways and Means Subcommittee on Social Security

1. **During the hearing Mr. Skwiercyznski expressed a number of concerns about what he perceives as mismanagement. Please provide your response to his allegations.**

Employees of the Social Security Administration (SSA) are represented by four unions – the Association of Administrative Law Judges, the National Treasury Employees Union, the National Federation of Federal Employees, and the American Federation of Government Employees (AFGE). Mr. Skwiercyznski is the President of the National Council of SSA Field Office Locals. While we have productive working relationships with the first three organizations, we have been unable to establish a similar relationship with AFGE. We welcome the opportunity to provide you with accurate information.

Union Allegation: Commissioner Astrue has refused to produce a comprehensive service delivery plan for congressional and public review.

SSA Response: One of the Commissioner's top priorities upon assuming office in February 2007 was to produce an up-to-date, relevant agency strategic plan (ASP). The 2008 - 2013 Agency Strategic Plan (ASP) was one of his first plans shared widely within SSA. While we asked for AFGE input, we received no response.

Our Chief Information Officer has lead responsibility for updating the ASP that will include service delivery and staffing initiatives. We are working with our stakeholders, including the unions, and the public in developing our new ASP. We expect to publish our new plan in early calendar year 2011, and we will provide a copy to the Subcommittee.

Until then, we are operating under our current strategic plan, which establishes clear and concrete goals and expectations. We have provided copies of our plan to Congress and, under a concerted, planned effort, management discussed the strategic plan initiatives with employees when the ASP was first issued. We continue to update our employees about new strategies.

Union Allegation: Very little of the [budget for fiscal year (FY) 2009 and FY 2010] money has been used to improve service delivery on the front lines in field offices and teleservice centers. The Commissioner's decision to provide 900 more positions in field offices appears to be a gesture that he made a week before this hearing to mollify this committee.

SSA Response: While eliminating the hearings backlog has been our primary focus since FY 2008, we have also been committed to improving service to the public in our field offices and teleservice centers. With the additional funding Congress has provided in our annual appropriations and the Recovery Act, we have made real and measurable progress. By the end of FY 2010, we will have nearly 4,000 more full-time front-line operational employees than we had at the end of FY 2007. This includes more than 500 additional hires for the

teleservice centers. We also provided increased overtime to allow our employees maximum flexibility to tackle the increasing workloads.

Union Allegation: Little has been done to correct serious problems with iClaims. While SSA asserts that every iClaim is reviewed by a technician and the claimant is contacted where necessary, SSA does not acknowledge that it can take days or weeks to get in touch with the applicant, who may believe s/he has successfully completed the application process. If these claims were filed with the assistance of a trained SSA employee, they would have been done correctly, without the need for recontact.

SSA Response: AFGE's allegation is not accurate. Our iClaim initiative is critical to our ability to address our growing workloads, and we closely monitor its use and make adjustments as needed.

It is important to note that we review *all* claims prior to adjudication, regardless of the method of filing, and, if necessary, we recontact claimants for additional information. The time it takes to recontact a claimant varies based on the contact information provided and the claimant's availability.

On-line filers have the advantage of applying for benefits at their convenience from their homes. They can pause the process at any point to gather additional documents or discuss options with family members. An online claimant need not wait for an office appointment to file the application—the claim can be conveniently filed online. Even with the time needed for recontact, the online claimant's application will, with few exceptions, be filed earlier than it would have been had he or she had to wait for an appointment. More importantly, under most circumstances, we will consider the date that the online claimant began filling out the claims application as a protective filing date.

We acknowledge that as we venture into online services, we will need to continue to improve the experience. In fact, we regularly upgrade our Internet claims software to improve the process. For example, a May 2009 release permits the system to consider work and earnings in determining and providing possible month-of-election choices. In February 2010, we enhanced the iClaim application to recognize month-of-election options for those beneficiaries born on the first day of the month. While we are proud of our current online services, they will keep getting better.

Union Allegation: Employees have been "banned from explaining month of election choices" with claimants whether they file through the Internet, face-to-face, or by telephone...few claimants are savvy enough regarding the intricacies of "month of election" that they don't need a basic explanation of their options before making a permanent decision on when to effectuate their benefit applications.

SSA Response: We have not banned our employees from explaining month of election (MOE) choices. While we do not attempt to influence a claimant's MOE choice, our technicians do provide information about different MOE options.

Our employees inform claimants of the amount of their unreduced benefits payable as well as the monthly amounts they would receive if they chose to take benefits earlier or later. Online filers are provided the same information and can get benefit estimates by using the link to the Retirement Estimator included in the application path. We provide claimants with information about known factors that may affect their MOE decision, such as the amount of earnings from work or self-employment, the effect of non-work months, protective filing, and retroactivity. Claims technicians also explain the concepts of reduced retirement benefits and delayed retirement credits including the effect of receiving retirement benefits on their survivors' benefits. All of this information is also available to claimants who file online.

Most claimants, however, do not wait to collect benefits. Over one-half of claimants take retirement at the earliest time possible. Some private retirement pensions require that choice, while some workers do not have the financial means to make a different choice.

Because when to start receiving benefits is a personal decision, our claims technicians should not attempt to influence the claimants' decision. The role of the technician is to provide Social Security program information rather than to weigh-in on the claimants' benefit decisions or provide financial planning advice. Our policy instructions can be found at http://policynet.ba.ssa.gov/poms.nsf/lnx/0200204039.

Union Allegation: SSA management continues to engage in unethical behavior in processing work and measuring the amount of work completed in an effort to inflate or impact productivity artificially.

SSA Response: Contrary to the Union's allegation, we have no reason to artificially inflate our productivity. In a recent audit, the Office of the Inspector General (OIG) reviewed counts for specific workloads and identified offices whose workloads had significantly increased from FY 2008 to FY 2009. OIG concluded that the workload changes they identified did not affect staffing for the six field offices they investigated. They did find, however, some cause for minor corrective actions, which we have taken. For example, one regional office found that one of its field offices was following a policy that was not consistent with typical field office procedures. That field office has since discontinued that practice.

Union Allegation: DDSs should be federalized to bring consistency to the initial claims decisions in the same way that the SSI program created a uniform system of benefits for the low-income blind, disabled and aged populations. SSA is not willing or able to take this step.

SSA Response: When we published final rules that implemented the 1980 Disability Amendments in May 1981, we established a framework for the Federal-State partnership and provided the States with management flexibility. The States would have control over management of their operation as long as their overall performance met the standards we established. Thus, we left the definition of detailed administrative responsibilities to the States. While we have discussed imposing additional administrative requirements on the States in light of the recent furlough situation, it would be very difficult to enforce any

violation. The Social Security Act limits our enforcement authority to taking over the State operation, a very complex and resource-intensive process. Accordingly, we have so far chosen to address the problem in other ways, both by trying to work with State officials and by shifting workloads to other States and to Federal components. We will continue to work with each State to minimize or eliminate furloughs of disability determination services (DDS) employees.

In addition, we will be working with congressional staff to have a legislative proposal introduced in Congress that would prohibit States from reducing hours or personnel in the DDSs without prior approval by the Commissioner.

2. **Please provide a summary of how much SSA space is owned and how much is leased. Also, how much of this space is underutilized, and what is SSA doing to ensure all space is utilized before obtaining additional space?**

Nationwide, we occupy 28,366,716 square feet of office space, of which 19,605,514 square feet is leased space, and 8,761,202 square feet is in Federal space. Based on our most recent submission to the Federal Real Property Profile, we do not have any space classified as underutilized.

Every year, we perform a service delivery assessment (SDA) on 20 percent of our offices nationwide. These SDAs consider projected changes in workloads, local populations, demographic trends, and area-specific factors that may affect staffing levels in a given location over a five-year timeframe (until the next SDA is completed).

Typically, office relocations occur when a lease expires. At that time, we determine our space needs based on the most recent SDA and current staffing levels. To ensure that the space request is in accordance with our Space Allocation Standards, the request requires executive approval from a Regional Commissioner or an Associate Commissioner.

3. **I understand you have established an Agency-wide working group to develop ideas to enhance equity and adequacy as well as simplify and streamline. When can the Subcommittee expect to see their recommendations?**

We established our Legislative Team to develop legislative proposals to improve the programs we administer and simplify and streamline their administration. We are currently reviewing several of the Team's proposals. If approved by the Commissioner and the Office of Management and Budget, we will be happy to share them with the Subcommittee.

We recently transmitted to Congress a number of legislative proposals for your consideration. In December 2009, we transmitted a package of 14 proposals that would simplify and improve certain aspects of the Old Age, Survivors, and Disability Insurance program and the Supplemental Security Income (SSI) program. We appreciate Congress' quick action on one of these proposals, the "*No Social Security Benefits for Prisoners Act of 2009*," which was signed into law on December 15, 2009. In January of this year, we sent

Congress a draft bill that would extend for five years the funding authority for two work incentive provisions.

As we mentioned earlier, we will be working with congressional staff to have a legislative proposal introduced in Congress that would prohibit States from reducing hours or personnel in the DDSs without prior approval by the Commissioner.

4. **Your testimony refers to a rise in threats to your employees. Is there anything this Subcommittee can do to assist you in addressing this situation?**

The number of threats and actual assaults to our employees and security guards has been rising at an alarming rate, due in part to the downturn in the economy and what appears to be a generalized frustration with government. In order to protect our staff and the public visiting our offices, we have taken a close look at our security program and are in the process of implementing actions to increase the level of security at our facilities. Our initiatives include:

- Modifying guard contracts to arm all guards at all facilities;
- Assessing the need to increase the number of guards at select locations based on an evaluation of risk;
- Providing guidance to regional offices on standards for Closed Circuit Television (CCTV) and duress alarms in our facilities;
- Installing CCTV in all SSA offices engaged in face-to-face customer service that do not currently have CCTV;
- Formulating a consistent alternative service policy for individuals who threaten our employees or facilities;
- Modifying our assessment procedures to correct physical security deficiencies more quickly and efficiently; and,
- Hiring an independent expert to review our security posture.

In addition, our OIG is involved in threat and incident response and in recent months has moved toward more proactive prevention efforts.

In terms of what the subcommittee can do to assist us, there are very real costs associated with current and future security needs, including those outlined above. We appreciate Congress' continued funding for our critical security efforts. For example, Section 206 of the *Social Security Protection Act of 2004* provides criminal penalties for the corrupt or forcible interference with the administration of the Social Security Act. The statute provides greater protection for our personnel, including contractors, State employees of the DDSs, and others

as designated by the Commissioner of Social Security. This legislation improves working conditions for our employees, allowing them to focus on serving the public.

5. **In your written testimony you mention that you have expanded your Wounded Warrior program to improve service. Please provide any additional information you might have about the SSA's efforts in this area.**

We are committed to serving our Wounded Warriors compassionately and efficiently. We have expanded our Wounded Warrior program and work collaboratively with the Department of Veterans Affairs (VA) and the Department of Defense (DoD) on outreach, coordination, and medical information sharing. Below we have listed recent activities to improve services for Wounded Warriors.

- In November 2009, we broadcast the webinar, "Social Security for Wounded Warriors," that provided information about our disability programs and expedited claims processing for Wounded Warriors. The webinar targeted service members, their family and friends, and advocacy groups. To date, there have been over 4,000 viewings of the webinar, representing the largest viewing audience in our webinar history.

- We established a dedicated mailbox, WoundedWarriors@ssa.gov , to respond to questions from the public. Thus far, we have responded to approximately 200 questions from veterans, including Wounded Warriors, and their families.

- We continue to work with numerous advocacy groups to assist service members and veterans applying for benefits.

- We provide training on our benefit programs to VA's Federal Recovery Care Coordinators and their Transition Assistance Advisors, as well as DoD's Recovery Care Coordinators. We perform this training at both the national and local levels.

- In May 2010, our Philadelphia Regional staff worked with Walter Reed Army Medical Centers to provide video conferencing, which will allow us to take applications and interview Wounded Warriors by video at Walter Reed.

- We have assisted both VA and DoD in locating service members and survivors of service members:

    - We provided VA with identifying information to use in locating surviving spouses of deceased veterans for retroactive payments.

    - We provided the U.S. Marine Corps with updated contact information on soldiers they were unable to locate for the purpose of providing enhanced benefits.

    - We assisted the Department of the Army in locating next of kin of fallen soldiers for the payment of benefits.

- We are working with the Department of Labor to explore opportunities for coordinating services for disabled veterans wanting to return to the workforce.

6. **How is field office productivity measured, what is the current level of field office productivity, and how has it changed in the last five years?**

We measure field office productivity in a workload by comparing how long it takes to complete the current year's work to the time needed to complete that same work the prior year. For example, if it takes 95 minutes this year to complete an action and it took 100 minutes last year, we would say productivity has improved by 5 percent in this workload. We take the time our field offices spend completing a workload, divide that by the number of actions taken, and then compare the results year over year.

We also factor in overhead items, such as leave and training, when calculating overall productivity. We calculate overhead as a ratio of direct work. More staff will use a higher total hours of leave, for example, so we look at the ratio to see if we are using more or less in overhead categories compared to the amount of work we are getting done.

In general, field office productivity has increased each year since FY 2006. In FY 2007, for example, we were 4.1 percent more productive than in FY 2006; in FY 2008 productivity increased by 4.8 percent over FY 2007; and in FY 2009 it increased by 7.3 percent. Throughout FY 2010, productivity continues to increase, but at a slower rate. Through May, field office productivity is up 4.3 percent compared to the same period in FY 2009.

7. **Please describe what financial literacy initiatives are underway at the agency, their benefits, and their costs.**

There are three major elements to our financial literacy initiative: 1) production of the annual *Social Security Statement*; 2) promotion and support for the Retirement Estimator; and 3) our research program.

- *The Social Security Statement* (http://www.socialsecurity.gov/mystatement/) provides personalized information about Social Security retirement, spousal, survivor, and disability benefits based on a worker's lifetime earnings. The Social Security Act requires that we mail a *Statement* to workers and former workers aged 25 and older and workers of any age who request it. We mail *Statements* to about 150 million Americans a year. By helping workers understand the scope of their Social Security benefits, we are helping them with their overall retirement planning. Thus, the *Statement* is an important financial literacy product.

- The Retirement Estimator (http://www.socialsecurity.gov/estimator/) is an online tool that produces personalized estimates of Social Security retirement benefits, based on a worker's actual Social Security earnings records. The estimator provides benefit data for

different retirement ages so that workers can better plan for retirement.

- The Research Program involves developing effective approaches to improve financial literacy, based on an evaluation of what works. Our program supports research conducted by experts outside the agency, fosters collaboration with other Federal agencies with similar goals, and develops data to conduct studies and evaluate other methods that may help workers make better retirement decisions.

The budget for financial literacy activities includes funding for the annual *Statement*, the Retirement Estimator, and research. Our budget for financial literacy activities in FY 2010 is $86.73 million. We requested $93.2 million for FY 2011 to continue our efforts. Most of these resources (about $70 million annually) fund the congressionally mandated *Social Security Statement.*

Budget for Agency Financial Literacy Activities (in millions)		
Category	**FY 2010**	**FY 2011**
Annual Statement	$70.0	$70.9
Retirement Estimator	$1.8	$0.1**
Research	$15.0	$22.3
TOTAL*	**$86.7**	**$93.2**

*Amounts listed above are rounded.

**We anticipate that the Retirement Estimator costs in FY 2011 will decrease as the website moves beyond the initial design and implementation phases.

8. Are you concerned about the quality of decisions being made by field office staff? How is field office decision quality measured?

We are satisfied with the quality of decisions made by our field office staff. Our Office of Quality Performance conducts an ongoing Transaction Accuracy Review (TAR) of our field offices' processing of Social Security and SSI field cases. The TAR assesses the technicians' accuracy adjudicating initial awards of Social Security and SSI benefits, SSI redeterminations, and a limited number of other issues.

The TAR shows that, for Social Security benefits, the overpayment dollar accuracy rate for FY 2008 was around 99.7 percent, while the underpayment dollar accuracy rate was almost 100 percent. For SSI, the overpayment dollar accuracy rate for FY 2008 was 89.7 percent, and the underpayment dollar accuracy rate was 98.3 percent.

9. Some caseworkers are expressing concern about the processing time for cases sent to the field office in Falls Church, Virginia. Please update the Subcommittee on the processing time of this facility and actions being taken to improve service.

We established the National Hearing Centers (NHC) to increase our ability to handle hearing requests. We transfer workloads from the most heavily backlogged hearing offices to an NHC to better balance the workloads across the Nation. Two-thirds of the cases transferred to the Falls Church NHC are aged cases, meaning that they would be 825 days old or older at the end of FY 2010. Thus, it is not surprising that the overall average processing time for cases handled in the Falls Church NHC is higher than the national average – 640 days versus 439 days. Please note the fact that once the Falls Church NHC receives the case, it is decided in an average of only 186 days.

SOCIAL SECURITY
The Commissioner

August 6, 2010

The Honorable Earl Pomeroy
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your May 21, 2010 letter requesting additional information to complete the record for the joint hearing on our disability claims backlogs. This hearing was held on April 27, 2010. Enclosed you will find the answers to your questions and Representative Danny Davis' questions.

I hope this information is helpful. If we may be of further assistance to you or your staff, please do not hesitate to contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

/s/

Michael J. Astrue

Enclosure

Questions for the Record
For the April 27, 2010 Hearing
On Social Security's Disability Claims Backlogs

Questions from Chairman Earl Pomeroy

1. **Please provide the following actual or projected information for disability claims at the initial claims, reconsideration, hearing, and Appeals Council levels, for each of fiscal years (FYs) 2008 through 2015:**

    a. **Number of receipts**

    b. **Number of cases processed**

    c. **Number of pending cases at the end of the fiscal year**

    d. **Average processing time for that level**

    Please see the attachment at the end of these responses. We based the projected workloads for FY 2010 through FY 2015 on the President's FY 2011 budget assumptions.

2. **The resources in the FY 2011 budget request do not allow the Social Security Administration (SSA) to make significant progress in reducing the initial claims backlog, yet in your testimony you say SSA's goal is to get back to the pre-recession level of pending initial claims by 2014. What will be different in FYs 2012, 2013, and 2014 to allow SSA to reduce this backlog to the pre-recession level?**

    The unanticipated economy-driven surge in disability workloads has challenged our ability to keep pace with the extra work. Our Chief Actuary projects that our disability claims receipts will peak in FY 2010 and start going down beginning in FY 2011. The additional resources we have received in the past two years have allowed us to increase our capacity to address this growth in claims.

    By the end of FY 2010, we expect to have a total of 2,800 more staff in our State disability determination services (DDS) than we had in FY 2008. With this additional staffing, and as our new employees become fully productive, we will accelerate our effort to reduce the number of pending cases, as we expect to decide 236,000 more disability claims in FY 2011 than in FY 2010. Our FY 2011 budget request provides the resources needed to support our continued momentum in our endeavor to reduce the backlog.

As part of our hiring efforts in the DDSs, we established extended service teams (EST) in several States to help the most backlogged areas. ESTs are centralized units in four DDSs that are similar to the National Hearing Centers (NHC). We placed these new units in DDSs that have a history of high quality and productivity and the capacity to hire and train significant numbers of additional staff. In FY 2010, we opened four ESTs—Arkansas (March 2010 with 100 employees), Mississippi (April 2010 with 50 employees), Virginia (May 2010 with 80 employees), and Oklahoma (June 2010 with 50 employees).

In addition, we added 237 new employees to our Federal disability processing units, which assist the DDSs in processing claims. We currently have a Federal unit in each of our ten regions and two units in Baltimore.

We are also improving the first steps of the disability process with technology solutions, updates and simplification of program rules, and adaptations of initiatives that helped reduce our hearings backlog. Our enhancements include:

- Our Quick Disability Determination (QDD) and Compassionate Allowances (CAL) initiatives that fast-track claims that are likely allowances. QDD uses a predictive model to identify certain claims, such as low birth-weight babies, cancer, and end-stage renal disease, in which the decision is highly likely to be favorable. CAL allows us to quickly identify applicants who are clearly disabled based on the nature of their disease or condition. The list of CAL conditions originally contained 25 rare diseases and 25 cancers. We added 38 new CAL conditions on March 1, 2010.

  We have held five public hearings to obtain critical information to develop and enhance this list of conditions and plan additional hearings in the near future. The information obtained at these hearings is also helpful for making other improvements to the disability process, such as updating our program rules. In FY 2010, we expect that our enhancements to QDD and CAL will allow us to fast-track about 140,000 applications for the most severely disabled Americans while maintaining decisional accuracy. Identifying and paying eligible claimants early in the disability process clearly benefits those with severe disabilities, while at the same time helping our backlog reduction efforts.

  Recently, we proposed a regulation to expand the single decision maker (SDM) authority to cases that are identified as QDD or CAL. SDM allows a disability examiner to adjudicate a case without a mandatory concurrence by a doctor.

- We are developing and implementing a common Disability Case Processing System (DCPS) for all 54 DDSs. Currently, each of the DDSs has its own unique case processing system, many of them based on an old programming language. In FY 2011, we will begin beta testing a common, web-based

system that will provide additional functionality and the foundation for a state-of-the-art disability process. We believe full DCPS implementation will make it easier to implement other important technology changes to improve the disability process.

- We are increasing the funds available for the existing medical consultant (MC) contracts for both State and Federal MCs. We will shift Federal MC case review support to the most distressed areas to ensure balanced service. The DDSs continuously work with the medical community to increase the number of doctors available to be MCs or to conduct consultative examinations, which are medical examinations of claimants that we request and pay for. We are also developing a recruitment strategy to market disability-related career paths to medical students and recent graduates.

We expect these steps will help us reach the pre-recession level of pending claims by FY 2014.

3. **Your testimony describes steps SSA is taking to improve certain aspects of the initial claims process. What evaluations is SSA doing to determine the extent to which these initiatives will speed claims processing or make it more likely that claimants will get the right decision as early as possible in the process?**

We began implementing many of the initiatives described in my testimony, including ESTs, only recently; therefore, it is too early to evaluate them fully. However, we are assessing each initiative on an ongoing basis.

We currently have evaluation protocols in place for the following initiatives:

eCAT (Electronic Claims Analysis Tool) –

- eCAT is a web-based application that aids the decisionmaker in documenting, analyzing, and adjudicating the disability claim in accordance with SSA regulations. We are reviewing eCAT's effectiveness in achieving decisional quality and consistency against its effects on cost and productivity.

QDD/CAL –

- We review the accuracy of these determinations on an ongoing basis.
- We routinely monitor the processing times of these claims. On average, the DDSs process QDD and CAL claims in less than two weeks.

iClaim –

- We review these claims as part of our Title II Transaction Accuracy Review. The overpayment accuracy rate for these claims is 99.81 percent, and the underpayment dollar accuracy rate is 99.42 percent. While the overpayment accuracy rate is roughly the same as the overall overpayment accuracy rate (99.38 percent), the underpayment dollar accuracy rate is better than the overall underpayment dollar accuracy rate (97.98 percent).
- We also plan to interview field office and DDS staff to determine how iClaim affects claims processing.
- Through our Satisfaction Insight Reviews, we routinely seek feedback from the public to determine its reaction to and satisfaction with iClaim and the Simplified 3368 (medical form). In FY 2009, we conducted an in-depth survey about satisfaction with online filing. We asked retirement applicants how much time they spent completing an iClaim application. The majority of survey responders, 59 percent, reported that they had completed the iClaim in 30 minutes or less, 30 percent reported that it took up to an hour, and the remaining 11 percent said they spent more than an hour. Satisfaction with these time frames remained high regardless of the actual time spent on the iClaim. At the 30 minute and one hour marks, 98 percent of responders rated the time spent as excellent, very good, or good; the rating declined when the time spent was over an hour, but was still very positive at 92 percent.

Health Information Technology (HIT) –

- From August 2008 through March 2009, we completed a 200-case review of the first HIT pilot in the Boston Region. Our review of the disability claims adjudicated in the Massachusetts DDS revealed that the HIT medical evidence request (MER) documentation in those claims conformed to our standards.
- From the end of February 2009 to May 2009, we conducted an Early Information Study (EIS) of 50 claims (25 allowances and 25 denials) from the Virginia DDS. We found no deficiencies related to HIT MER. We will complete a similar EIS for each DDS when it begins receiving HIT MER.

4. **As you know, some states have included DDS employees in furloughs of state government employees, even though the DDSs are completely funded by SSA. The Subcommittee is very concerned about the impact of these furloughs on the already large backlog of initial disability claims. Have you considered revising your regulations to prohibit this practice? If not, why not? What would be the advantages and disadvantages of such a change?**

Neither the Social Security Act nor our regulations considered the type of personnel actions that some States have been pursuing as they continue to experience greater economic stress. The Act does not provide a mechanism for interfering in the management of State agencies beyond completely taking over a State operation. Our regulations do not provide any recourse for challenging a State's administrative decisions unless a State's performance or quality falls below the standards we have

established. Current regulations require many months of unsatisfactory performance before we can pursue a time-consuming, complicated process to take over the State's operation. We have been addressing the problem by trying to work with State officials and by shifting workloads to other States and to Federal components. We will continue to work with each State to minimize or eliminate furloughs of DDS employees, but a legislative fix is necessary to provide us with some intermediate authority to address these types of administrative actions.

5. **SSA publishes performance targets and outcomes for most of the stages of the disability process in its annual budget documents and *Performance and Accountability Report.* However, the agency does not publish this information for the reconsideration stage of appeal. This makes it difficult for Congress to get a complete view of the disability claims backlog problem. Wouldn't it increase transparency and provide more complete information if SSA included this data in its public documents? Does SSA have plans to include this information (particularly the number of pending cases and average processing times) in the future? If not, why not?**

   Although we estimate reconsideration receipts, completed cases, and pending cases as part of our budget process, the performance measures we report in our budget documents and the Performance and Accountability Report link to the strategic goals and objectives set forth in our *Agency Strategic Plan* (ASP). Our current ASP does not have a reconsideration-specific strategic goal; however, we are developing a new ASP for publication in early calendar 2011. As we establish our strategic goals and long-term outcomes for our disability claims process, we will consider including performance measures for all stages of the disability process. Once the Office of Management and Budget approves our performance measures, we will publish corresponding performance targets and outcomes in our annual budget documents and *Performance and Accountability Report.*

6. **You testified that cases that are processed through the reconsideration level are more thoroughly developed when they reach the hearings level than cases that have only been processed through the initial level. Please provide a summary of any studies the agency has conducted that show that cases adjudicated at the reconsideration level can be processed more quickly at the hearings level, on average, than cases that were processed only through the initial claims level.**

   While we do not have studies showing whether disability claims that have been through the reconsideration process are more thoroughly documented than those that go directly to the hearing level, a second person reviews a reconsideration case and obtains any new medical records or evidence of an impairment.

   Our longitudinal data indicate that 8 to 11 percent more disability claims go to hearing offices in States without the reconsideration step than in States with the reconsideration step. This increase in the proportion of claims proceeding to the hearing offices creates a larger backlog, increases the processing time for these

claims, and therefore makes it more likely that the claims will require further updating and development.

7. **We know that SSA has had success with initiatives at the hearings level that screen cases to determine which ones are likely to be allowed on the record, without a hearing. Has SSA conducted any studies to determine to what extent the approximately 15 percent of cases likely to be allowed at the reconsideration level are cases that, if appealed directly to the hearing level, could be allowed without a hearing, through the Senior Attorney Program or similar initiatives? If so, please summarize the results of these studies. If not, do you plan to conduct such studies in the future, so that the advantages and disadvantages of reinstating the reconsideration level can be better assessed?**

   We have not conducted these studies. In 2009, however, we established a screening unit in the San Francisco Regional Office of Quality Performance to screen newly-received hearing requests from the Oak Park, Michigan Hearing Office. The unit recommended an on-the-record allowance in 19 percent of those cases. We concluded that it is likely that many of these cases would have been allowed at the reconsideration level-a similar process, resulting in earlier allowances.

   Nationally, 13 to 15 percent of all reconsiderations filed result in an allowance with an average processing time of 154 days, which is much faster than 456 days, the average processing time for an allowance at the hearing level for States with reconsideration.

   Due to our current pending levels, we have not planned further studies at this time. As you know, we do not intend to reinstate reconsideration in Michigan next fiscal year. If we do reinstate reconsideration in Michigan, we will closely monitor the situation.

8. **While SSA has made progress in reducing the unprecedented backlog of disability hearings, I am still concerned about what might happen in FY 2012, FY 2013, and after your backlog reduction plan ends in FY 2013, as the large backlog of claims now pending in the state DDSs continue to flow into SSA hearing offices.**

   a. **How many Administrative Law Judges (ALJs) will SSA need not only to eliminate the hearings backlog by the end of FY 2013, but also to ensure that it does not begin to grow again in FY 2014 and FY 2015?**

      Based on current workload projections, we believe that if we receive full funding for our proposed ALJ corps of 1,450 and necessary support staff hiring, we will have sufficient staff on hand to eliminate the hearings backlog and prevent it from recurring. Our projections factor in the effect of the DDSs' efforts to reduce the initial claims pending.

Since we implemented the Hearings Backlog Reduction Plan in FY 2007, we have adjusted the size of the ALJ corps to address increasing workload estimates. We review the number of ALJs and support staff each year as we develop our budget estimates, and we will reevaluate again this year as we develop our FY 2012 budget.

b. When do you expect to hire the ALJs needed to bring the ALJ corps up to this level?

This fiscal year, we plan to hire 166 new ALJs above attrition and have hired 100 new ALJs through the end of May 2010. We plan to bring two additional classes of ALJs on duty this fiscal year. Beyond this fiscal year, we will hire ALJs according to the following schedule:

Year	Approximate Date	ALJ hires
FY 2011	April 2011	50
	June 2011	20
FY 2012	November 2011	51
FY 2013	November 2012	35
	April 2012	30

c. What is your target support staff-to-ALJ ratio through the end of FY 2013, to achieve the goal of eliminating the hearings backlog by that date? What support staff-to-ALJ ratio will be needed in FY 2014 and FY 2015 to ensure that the backlog does not rise again?

Our current support staff to ALJ ratio is 4.5 to 1. We believe this ratio is sufficient to achieve our goals. Therefore, we do not expect to significantly change this ratio.

9. SSA has hired a significant number of ALJs and support staff, and these hires have certainly played an important role in making progress towards eliminating the hearing backlog. However, the SSA Inspector General (IG) and others have suggested that staffing may still be insufficient, that the staffing mix may not be right, or that some hearing offices may have not gotten the staff they need. What else can SSA do to make sure it has enough staff, and the right mix of staff, to maximize ALJ productivity?

We agree that the right number and mix of support staff, such as legal assistants and decision writers, for each ALJ will allow us to continue to reduce the backlog. We continuously monitor the entire hearing process and hire staff as necessary to support our ALJ corps. Since each hearing office is unique, the number of support staff needed per ALJ and the optimal mix of support staff can vary from office to office.

As I stated during the hearing, we have implemented several initiatives to maximize our ALJ productivity. We are opening National Case Assistance Centers to assist with decision writing and case preparation. We also continue to realign service areas and permanently transfer cases to balance workloads and maximize capacity.

10. **In your testimony, you stated that a recent GAO report "has validated our substantial progress, finding that we have a 78 percent chance of meeting our target date of 2013 for backlog elimination." This report (GAO-09-398, September 2009) says, specifically, that there is a 78 percent chance of eliminating the backlog by the end of FY 2013 if SSA's assumptions about ALJ hiring, availability, and productivity are achieved in practice. If the assumptions are not met, the likelihood of success decreases significantly. Does SSA have a "Plan B" that would take effect if these assumptions are in danger of not being met?**

With adequate funding, we are confident that we will achieve our plan and eliminate the hearings backlog by the end of FY 2013. In fact, we are exceeding our plan in a number of areas. For example, we set our FY 2010 pending goal at 707,000 hearing requests. By February 2010, we had already met our goal, and through May, the backlog had fallen to less than 695,000 pending requests.

We continually monitor our hearings backlog reduction activities and swiftly address problems when they arise. For example, we continue to employ national tools and strategies, such as service area realignments, the NHCs, National Case Assistance Centers, and permanent case transfers, to assist our most heavily backlogged offices. As we develop our FY 2012 budget, we will reevaluate our plan and rebalance our resources as needed.

11. **The GAO report cited above also states that SSA's backlog elimination plan could have unintended effects on various aspects of hearing office performance and could also impact the workloads of other SSA offices involved in the disability process. What is SSA doing to identify and address potential adverse effects or workload increases that may result from the backlog elimination plan?**

We recognize that eliminating the hearings backlog has ramifications throughout the agency. Through our budget and management processes, we fully address the effect of these increased workloads on other agency components. We continually monitor our performance, workloads, and staffing to ensure that we respond to changes resulting from the hearings backlog reduction plan, while making certain the quality and accuracy of work does not suffer.

12. **In response to a previous information request from the Subcommittee, SSA was unable to provide information about the average processing time for effectuating payment of retroactive benefits after a case has been allowed at a hearing. I am concerned that SSA does not appear to be tracking information about the timeliness of these payments, which in many cases may be funds that**

beneficiaries desperately need. I also understand that the SSA IG is examining delays in issuing monthly or retroactive payments.

a. Please provide any available data on average processing times for the following:

i. The date a favorable hearing decision is made to the date ongoing monthly payments are initiated;
ii. The date a favorable hearing decision is made to the date retroactive benefits are paid; and
iii. The date a favorable hearing decision is made to the date payments are initiated for any auxiliaries who are entitled.

Please provide these average processing times for the following categories: title II only cases, title XVI only cases, concurrent cases, and overall average processing times. Also, please indicate what SSA components are responsible for effectuating each of these types of payments.

i. The date a favorable hearing decision is made to the date ongoing monthly payments are initiated;

Based on fiscal year data through May 21, 2010, ongoing Title II monthly payments are initiated in an average of 17.2 days from the date of a favorable hearing decision, and ongoing Title XVI monthly payments are initiated in 26 days. We use different systems to process these allowances and treat concurrent claims as separate Title II and Title XVI allowances. Therefore, we cannot calculate the average processing time for concurrent claims.

ii. The date a favorable hearing decision is made to the date retroactive benefits are paid; and

When possible, we pay past-due benefits at the same time that we issue the first monthly benefit payment. In many cases, calculating retroactive benefits is quite complex. We must consider factors such as attorney fees and workers' compensation benefits when determining the amount of past-due benefits. In these situations, we do not want to delay monthly cash benefits. Therefore, we immediately pay on-going monthly benefits and handle the retroactive payment separately.

Our current management information systems cannot capture the length of time between initial benefit payments and subsequent actions, such as a separate payment for retroactive benefits. We treat these actions as stand-alone events. Our systems recognize the actions needed to pay past-due benefits as a separate event when calculating processing time and will not add this time to the processing time for issuing the initial check.

iii. The date a favorable hearing decision is made to the date payments are initiated for any auxiliaries who are entitled.

We do not have the management information needed to provide this figure.

Also, please indicate what SSA components are responsible for effectuating each of these types of payments.

Our Program Centers (PC) effectuate Title II hearing allowances, and the claimant's servicing field office effectuates Title XVI hearing allowances. When a claimant files a concurrent claim, we send the Title II hearing allowance to the PC and the Title XVI hearing allowance to the field office for effectuation.

b. Does SSA intend to begin more comprehensive tracking of the timeliness of retroactive payments, including those actions taken in field offices, payment centers, and the Office of Disability Operations? If not, how can the agency know if there are problems, and develop a solution?

We are developing a measurement system that will calculate processing times for payment of retroactive benefits, but we do not yet have a target date for implementing this system. We currently have in place several workload management controls, such as monthly systems alerts, to track cases until we pay all owed benefits.

13. You testified that SSA is developing a new Occupational Information System to replace the outdated Dictionary of Occupational Titles (DOT). How much will this initiative cost? How is it being funded? Does SSA have a fully-developed budget for replacing the DOT? What is the time line for developing a replacement for the DOT and implementing it in the adjudication process?

We have established the Occupational Information Development Advisory Panel to advise us on a replacement for the outdated Dictionary of Occupational Titles (DOT). The DOT has been a cornerstone of our disability policy, and we have relied on it to determine whether a claimant could do his or her usual work or any other work in the national economy. The Department of Labor, however, has not significantly updated the DOT since 1979 and has no plans to do so. We must replace the DOT with updated definitions and objective measures of the requirements for work so that we can continue to adequately adjudicate claims for disability benefits.

We spent many years pursuing a number of options before concluding that we had to develop our own occupational information system (OIS). In FY 2009, we spent $342,000 on developing the OIS. We expect to spend $3,714,000 this fiscal year and $13,360,000 next fiscal year.

We fund this project under our section 1110 budget authority for research and demonstrations. Currently, we cannot accurately estimate this project's total cost as we are completing the basic research and development activities that will provide the information needed to produce these estimates.

We currently have several critical project activities underway. We are conducting a study to identify occupations of interest and collect other information about claimants' residual functional capacities and vocational characteristics. We also anticipate awarding a number of contracts this fiscal year to develop a business process for conducting job analyses and other data collection and to obtain necessary expertise in the areas of vocational rehabilitation and industrial/organizational psychology. This contracted work should be completed in FY 2011 and will form the foundation for the basic research and development activities necessary to provide more definitive cost estimates.

While we need to complete basic research and development activities before we can state more definitely when the new system will be available, we expect to have information on occupations that are most frequently found among our disability claimants' work histories by the end of FY 2014.

Questions from Representative Danny K. Davis

1. **What are the primary reasons that the Chicago hearing office backlog remains so high?**

Several factors have contributed to the Chicago Hearing Office's backlog, but we are beginning to improve service in this office.

ALJs in the Chicago Hearing Office had been performing below the national average. For the first seven months of this fiscal year, the Chicago Hearing Office produced an average of 1.81 dispositions per day per ALJ. By contrast, the national average for that same period was 2.36 dispositions per day per ALJ.

Although Chicago ALJs had been performing below the national average, they are increasing their productivity. In October 2009, they issued an average of 1.45 dispositions per day per ALJ, while in March, April, and May 2010 they issued 2.28, 1.95, and 2.18 dispositions per day per ALJ, respectively. In addition, the number of Senior Attorney Adjudicator (SAA) dispositions per day has increased. The Chicago Hearing Office SAA dispositions increased from 2.54 dispositions per day in October 2009 to 3.30 dispositions per day in May 2010. Due in part to these productivity increases, the office's backlog is decreasing. The number of pending cases has decreased from 6,545 at the beginning of this fiscal year to 6,088 at the end of May 2010.

In FY 2009, the Chicago Hearing Office's Chief ALJ and another experienced ALJ transferred to the National Hearing Center in Chicago. We have recently added two

ALJs in the Chicago Hearing Office--one new hire and one with prior ALJ experience. We believe these hires will also help improve the office's productivity.

2. **What data indicate that an office in Gary, Indiana will reduce the backlog in the Chicago hearing office?**

   Please note we will be opening a new hearing office in Valparaiso, Indiana, not in Gary, Indiana. The Valparaiso Hearing Office will take hearing requests from Gary.

   The Valparaiso Hearing Office will not assist the Chicago Hearing Office with its workload; rather, it will assist the Orland Park Hearing Office. When determining which Illinois hearing offices needed assistance, we analyzed workload data related to the number of hearing requests and the average number of cases pending per ALJ. Those numbers indicated that the Orland Park Hearing Office was in greater need of assistance than Chicago, which has a lower number of receipts relative to other Illinois hearing offices.

   We are assisting the Chicago Hearing Office in other ways. Since March 1, 2010, our Virtual Screening Unit (VSU) has been screening the Chicago Hearing Office's hearing requests for possible on-the-record decisions. We expect that this initiative will further reduce the Chicago Hearing Office's backlog.

3. **Using the data analyses, please indicate how and to what extent you project that the new Gary office will reduce the backlog in each of the following hearing offices: Chicago, Orland Park, Peoria, Oak Brook, and Evanston.**

   Of the offices listed, the new hearing office in Valparaiso will help reduce the backlog in only the Orland Park Hearing Office. The Valparaiso office will serve a number of areas currently served by Orland Park, including Gary, Hammond, and Merrillville.

   The Peoria Hearing Office used to handle hearing requests from the Danville, Illinois service area. To help the Peoria Hearing Office with its workload, our San Antonio, Texas Hearing Office now handles hearing requests from the Danville service area.

   Based on the number of hearing requests and average pending cases per ALJ, we do not provide assistance to the Oak Brook and Evanston offices. We will continue to monitor those hearing offices' statuses and provide assistance as needed.

4. **How does SSA plan to assign cases to the new hearing office in Gary, and how will that plan affect the workload in the Chicago hearing office?**

   We plan to permanently transfer pending cases from Orland Park to Valparaiso. The new hearing office will also receive hearing requests from field offices that serve Gary, Hammond, Merrillville, and Valparaiso. ALJs in the Valparaiso Hearing Office will not be handling any hearing requests from the Chicago Hearing Office.

5. **What analyses have you done to determine whether additional efforts will be needed to decrease the backlog in the Chicago hearing office even with the new Gary hearing office?**

   In our efforts to balance hearing workloads, we constantly review detailed national workload data, such as average processing time, average cases pending per ALJ, and the average age of pending cases. Based on our workload analysis, we target assistance to hearing offices and are assisting Chicago as outlined above.

6. **In addition to opening the hearing office in Gary, what steps, if any, are planned for reducing the backlog in the Chicago hearing office?**

   As noted above, we hired two ALJs for the Chicago office and provide VSU assistance to screen cases for possible on-the-record allowances.

7. **What are the expected time frames for opening the new hearing office in Gary and implementing any additional steps to ensure that the backlog in the Chicago hearing office is reduced?**

   We plan to open the Valparaiso Hearing Office in early September 2010. In addition to the assistance we described, we will continue to monitor that hearing office's workload data and provide additional assistance as needed.

   Attachment

Attachment for Question 1

Initial Disability Claims, Reconsiderations, Hearings, and Appeals Council Workload Data
FY 2008 to FY 2015

	FY 2008	FY 2009	FY 2010 YTD through Apr.	FY 2010 of FY 2011 President's Budget	FY 2011 of FY 2011 President's Budget	FY 2012 Projected	FY 2013 Projected	FY 2014 Projected	FY 2015 Projected
Initial Disability Claims - Title 2/Title 16/Concurrent*									
Receipts	2,605,362	3,024,418	1,862,264	3,342,400	3,275,400	3,192,000	2,887,400	2,705,800	2,705,500
Processed	2,607,282	2,812,918	1,827,927	3,081,167	3,317,487	3,202,850	3,105,210	2,951,140	2,705,500
Pending	556,670	779,854	810,756	1,041,087	999,000	988,150	770,340	525,000	525,000
Overall Processing Time	105.6	100.6	111.9	132.0	141.0	138.0	125.0	96.0	80.0
DDS Reconsiderations- Title 2/Title 16/Concurrent *									
Receipts	572,631	643,916	427,988	761,859	853,056	821,917	799,015	750,400	697,246
Processed	560,365	598,098	407,083	722,347	870,041	831,917	837,015	800,401	697,246
Pending	115,059	161,264	179,587	200,776	183,791	173,791	135,791	85,790	85,790
Overall Processing Time - T2 Only	284.7	264.7	277.6	N/A	N/A	N/A	N/A	N/A	N/A
ALJ Hearings									
Receipts	589,449	622,851	400,027	708,600	749,900	729,800	707,500	667,400	611,300
Processed	575,380	660,842	427,707	724,700	799,200	826,200	818,500	667,400	611,300
Pending	760,813	722,822	695,142	706,700	657,400	561,000	450,000	450,000	450,000
Overall Processing Time	514	491	439	485	460	381	270	270	270
Appeals Council									
Receipts	92,454	106,896	69,533	119,500	131,800	136,300	135,000	110,078	100,825
Processed	63,407	89,066	51,800	131,800	136,300	135,000	135,000	110,078	100,825
Pending	62,210	80,040	97,773	80,000	80,000	80,000	80,000	80,000	80,000
Overall Processing Time	238	261	328	370	340	340	340	340	340

* Includes Federal Assistance

Post-Hearing Questions for the Record
Submitted to Ms. Marianna LaCanfora
From Senator Daniel K. Akaka

"The Federal Government's Role in Empowering
Americans to Make Informed Financial Decisions"
July 15, 2010

1. **In your testimony, you noted that only a fraction of Americans know their full retirement age. Without this knowledge, Americans will not be able to make informed decisions on when to claim retirement benefits.**

   What must be done to ensure that all workers are aware of their full retirement age, so they can make informed retirement decisions?

The *Social Security Statement* that we mail each year to workers nationwide contains personalized information about Social Security benefits, including the person's full retirement age. We use feedback from public surveys and other measurement techniques to make improvements or modifications to the *Statement*.

We also created a research program to test what works. Our Financial Literacy Research Consortium (FLRC) supports research by experts outside the agency to design and test ways to improve financial literacy and foster collaboration with other Federal agencies with similar goals. The FLRC consists of cooperative agreements supporting research centers at three institutions: Boston College, the RAND Corporation, and the University of Wisconsin-Madison. The centers started work in October 2009 and will report the results of their first year projects at a public conference in November 2010. One project underway will help evaluate the different ways of presenting the choice of what age to begin Social Security retirement benefits. We will use findings from the FLRC research to refine and focus the information provided and identify effective ways to deliver it.

2. **The U.S. Social Security Administration (SSA) chairs the Financial Literacy and Education Commission (FLEC) Research and Evaluation working group. One of the challenges facing the FLEC is the development of measures to evaluate the impact of member agency programs on financial capability and outcomes.**

   Please describe the steps SSA is taking to assist the Department of the Treasury in the development of these measures.

SSA is helping Treasury develop content for a research resource clearinghouse that will include tools, metrics, data resources and summaries of research findings to support evaluation of financial capability at the individual, program, and national levels. These research resources will be made available to the public through the FLEC website, http://mymoney.gov./

We also expect the FLRC to be a key contributor to the FLEC group and its research and evaluation goals, and to serve as a valuable source of experts for the FLEC.

3. **Dealing with the most severe recession since the Great Depression, Americans are faced with significant economic challenges and limited resources. Therefore, it is vital that Federal financial literacy efforts are both effective and efficient.**

   How is SSA working with FLEC member organizations to coordinate and eliminate duplication of research efforts?

We have already held discussions with several FLEC member agencies including Treasury, the Department of Health and Human Services, the Securities and Exchange Commission, the Department of Education, and the Department of Labor, to reduce the likelihood of duplication and foster collaboration and coordination of activities.

We report to the FLEC about the research sponsored by the FLRC. Beyond our interactions with FLEC, we are working to eliminate duplication in general by interacting with private funders such as the Financial Industry Regulatory Authority Investor Education Foundation and the National Endowment for Financial Education.

The FLEC Research and Evaluation Working Group, headed by SSA staff, is working with Treasury to develop a research resource clearinghouse that would include a coordinated database of financial literacy research initiatives sponsored by FLEC member agencies. This working group is also recommending the establishment of a group of research experts that would facilitate interactions among FLEC agencies and the research community.

The FLEC Communication and Outreach Working Group, also headed by SSA staff, is developing a monthly newsletter, a repository for archiving and updating financial literacy related information from the FLEC agencies, and a FLEC directory with relevant contact information.

Conducting ongoing reviews of research projects is also an important part of our program management goal to reduce duplication. Program and grants management staff review quarterly reports to ensure we achieve our objectives. All research project applications must include a statement that describes all relevant projects and funding the researchers receive from any source (public or private). This is a useful tool for identifying any funding overlap for research projects and eliminating duplication of effort.

SSA, in conjunction with the three FLRC centers, uses an expert Panel of Outside Scholars to comment on current research projects and suggest areas for future work. This panel of third party experts is very diverse – they are practitioners, non-profit organization and government policymakers, and academics specializing in different disciplines. Having such a diverse panel significantly widens the reach of available consultative expertise and access to knowledge about existing research activities and cutting edge initiatives. Receiving timely input from experts in the field on an ongoing basis reduces the likelihood of duplication of effort and fosters the development of innovative projects.

4. **Please describe your top three recommendations on how we can improve the FLEC.**

Based on our participation in the FLEC, our top recommendations for improvement are:

- Establish a research resource clearinghouse to support the development of effective programs based on research and evaluation. The clearinghouse would provide metrics to measure program impact, information about useful data sources and relevant research findings, and describe active Federal research programs. The clearinghouse resources would improve program development and coordinate research activities.
- Improve outreach to achieve the FLEC objectives of coordinating financial education efforts throughout the Federal Government, supporting the private sector in providing financial literacy programs, and encouraging the synchronization of efforts between the public and private sectors.
- Establish a research network to support interactions between the government and the research community on financial literacy research and program development. These interactions would provide Federal agencies an opportunity to get valuable research insights that could improve the effectiveness of Federal financial literacy programs. A research network would also allow FLEC agencies to communicate high priority research topics directly to the research community to encourage new work and partnerships.

Coordinating Federal financial literacy activities and research across the Federal Government is a key FLEC objective. Our significant involvement in FLEC working groups has given us the opportunity to make these recommendations. As we note in our responses above, we are currently working with Treasury to implement these recommendations.

SOCIAL SECURITY

The Commissioner

September 28, 2010

The Honorable Carl Levin
Chairman
Permanent Subcommittee on Investigations
Committee on Homeland Security
and Governmental Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Thank you for your August 31, 2010 letter requesting additional information to complete the record for the hearing, *Social Security Disability Fraud: Case Studies in Federal Employees and Commercial Drivers Licenses*. This hearing was held on August 4, 2010. Enclosed you will find the answers to your questions, as well as the answers to Senator Coburn's and Senator McCaskill's questions.

Our response to question 36 contains materials that we may release to Congress under subsection (b)(9) of the Privacy Act of 1974. As this information could not otherwise be released to the public because the data could be used to identify living people, we suggest that it not be released further.

I hope this information is helpful. If we may be of further assistance to you or your staff, please do not hesitate to contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

I am sending a similar letter to Senator Coburn.

Sincerely,

Michael J. Astrue

Enclosures

SUPPLEMENTAL QUESTIONS FOR THE RECORD
FROM SENATOR CARL LEVIN

1. Provide the status of SSA's efforts to analyze and expand its data matching processes designed to detect beneficiaries who may be receiving disability payments fraudulently or improperly.

We are actively looking at ways to expand our data matching processes to detect beneficiaries who may be receiving disability payments improperly. Among other things, we are considering the cost-effectiveness of matches to Federal payroll data and pursuing an internal match of SSA payroll data.

Continuing Disability Review Enforcement Operation (CDREO) Predictive Model

We developed a CDREO predictive model that uses available data to predict the likelihood that a beneficiary has a large overpayment. We used historical data from our Disability Control File (DCF), our Master Earnings File, and our Master Beneficiary Record to develop statistical models that describe beneficiary characteristics that are associated with a large overpayment amount. From these models, we generate a score for beneficiaries with likely overpayments. We use this score to determine the highest probability of a large overpayment.

Our preliminary tests are encouraging. Seventy percent of the cases that the model identified as being most likely to have significant overpayments did, in fact, have large overpayment amounts. If we had worked the same number of cases at random without using modeling, we would have identified only about 25 percent with large overpayment amounts. Targeting our resources to the most significant cases will provide us with a higher return for our efforts.

We are currently working with our New York Regional Office (NYRO) to pilot our predictive model on the latest CDREO. We plan to evaluate the costs and the benefits of our predictive model by late summer 2011 and make a decision shortly thereafter.

Substantial Gainful Activity (SGA) Early Warning System

The NYRO proposed a pilot project that uses both our administrative records and the Office of Child Support Enforcement (OCSE) data to identify whether a Social Security Disability Insurance (SSDI) beneficiary is performing SGA. Using this data allows us to identify SGA earlier than we could using our CDREO process. This pilot differs from our previous assessment of OCSE data in that it would use our administrative data in combination with OCSE data to reduce the number of unproductive cases, thus potentially increasing the return on investment.

The NYRO would match data from several online systems, including our DCF and the OCSE National Directory of New Hires to screen SSDI beneficiary records for unreported work activity. The process identifies those beneficiaries in current pay status whose records

indicate that they earned more than $1,000 after disability had begun and for whom we had not begun a work continuing disability review (CDR).

The NYRO tested the process on a random sample of 3,000 SSDI beneficiaries residing in New York or New Jersey and identified 150 records (five percent of the total). The next steps in the project include identifying a 1 percent random sample from SSDI beneficiaries residing in New York or New Jersey, identifying the number of cases that meet the criteria, working the cases identified, and performing a cost-benefit analysis.

Work Number Data Agreement

The Work Number is a commercial wage verification firm that maintains an up-to-date database for companies who subscribe to the service and provides a quick and efficient means for us to verify wages. We use the Work Number and other wage verification companies to verify work activity, eliminating the time consuming process of direct employer contacts. We generally receive the worker's gross wages for the twelve most recent pay periods, total wages for the past two years, and the number of hours worked.

We currently use the firm's free fax service, which provides responses in 7-14 days. We are looking into moving to the Work Number's fee-for-service system, the Express Service, which provides immediate responses. We are in the early stages of investigating the use of the Work Number Express Service to improve our work CDR process and for other program integrity efforts.

Workers' Compensation Data Agreements

In accordance with section 224(h) of the Social Security Act, we are pursuing an agreement with the Department of Labor to develop a computer data-matching program to share data on beneficiaries who are receiving Federal Employees Compensation Act benefits. We currently receive information from the Office of Personnel Management for those beneficiaries who receive disability retirement.

We continue to search for other avenues for information gathering. Obtaining accurate and timely data regarding receipt of Workers' Compensation information is critical to reducing improper payments to our disabled beneficiaries.

2. Provide legislative recommendations for reducing the complexity of the back-to-work laws currently in effect for the disability program.

We are developing a proposal to simplify the work incentive provisions in the SSDI program. One of the issues that we are currently analyzing involves the interaction between work incentives, Medicare eligibility, and provisions of the new Affordable Care Act. We will provide our legislative recommendations to you as soon as the Administration approves them. We look forward to working with Congress on improving the SSDI program from both a beneficiary ease-of-understanding and a program stewardship perspective.

SUPPLEMENTAL QUESTIONS FOR THE RECORD FROM SENATOR TOM A. COBURN, M.D.

1. **Case Study No. 2 is a Transportation Safety Administration screener that SSA approved for DI payments in 1995 for mood and anxiety disorders, but began full-time federal employment in 2003. How is it possible for someone to work a full-time federal job for six years and also collect disability payments?**

This case is unusual and must be viewed in the context of the totality of the agency's workload. Beginning in late fiscal year (FY) 2008, we began to experience a significant increase in initial disability applications due to the downturn in the economy, and disability claims continue to rise to unprecedented levels. The same employees who handle the post-entitlement issues (like return to work) are responsible for handling new applications, and, as important as we know program integrity is, the workload to make initial payments to beneficiaries must take precedence.

Although the Internal Revenue Service (IRS) match identified that the beneficiary had earnings indicative of work, we could not verify the work. Reported earnings require further investigation, and according to the Computer Matching and Privacy Protection Act, we cannot take action based solely on the fact that the beneficiary was identified by the IRS match. Also, in many cases where a beneficiary is working, that work does not preclude the beneficiary from receiving benefits.

Our preference is to get the information directly from the beneficiary if possible and if not, to get the beneficiary's consent to contact his or her employer. This policy recognizes that the beneficiary is often the most efficient source of earnings information. We respect a beneficiary's wishes to keep his or her beneficiary status confidential, as long as we can obtain the evidence we need.

In order to determine whether a beneficiary is performing substantial gainful activity (SGA), we must obtain evidence of monthly earnings amounts. Our policy requires us to make reasonable efforts to obtain preferred evidence of monthly earnings from the beneficiary or the employer. If we are unable to obtain preferred evidence of earnings, we can use secondary evidence of earnings, such as the earnings posted to our records, to make work continuing disability review (CDR) determinations.

When we attempted to verify the work activity in this case, the beneficiary was uncooperative and refused to allow us to contact her employer. Instead of following our policy of using secondary evidence of earnings, we continued to try to obtain verification and did not take action to adjust her benefits (see Question 2 for current status).

2. **In your testimony, you state that GAO did not conclusively prove fraud in any of the 20 cases. At what point would this individual be considered to have committed fraud:**

   a. When she returned to work and failed to report it to SSA?
   b. When she failed to return the Work Continuing Disability Review in 2005?
   c. When she accepted an increase in benefits in 2005, 2006, and 2007 based on her current work without contacting SSA?
   d. When she called SSA and asked them not to call her employer for a work review, but failed to complete the Work Activity Report?
   e. When she accepted the $250 stimulus check?
   f. When she was videoed by GAO working as a TSA screener?
   g. When she personally admitted to GAO that she was working full time and also receiving disability benefits.

   My testimony referred to legally being able to prove fraud and considered that a summary of alleged information from a case file does not always reveal the entire story. The Social Security Act (Act) identifies various types of fraud that may occur in connection with the receipt of benefits under Titles II and XVI of the Act.[1] Under the Act, fraud can occur either through affirmative acts, such as the falsification of a document, or by knowingly failing to report an event that affects the initial or continued right to the payment received. But to prove fraud under the Act, the prosecution must show ***fraudulent intent*** on the part of the beneficiary – not just the intent to deceive, but also the intent to receive greater payment from the Government as the result of the deception.[2] The standard to prove fraud under the Act is higher than for fraud prosecuted under Title 18 of the United States Code, which requires "merely the intent to deceive or mislead."[3]

   When we become aware of a case of potential fraud, we refer it to our Office of the Inspector General (OIG). The OIG's Office of Investigations (OI) conducts and coordinates investigative activity related to fraud, waste, abuse, and mismanagement in our programs and operations, including wrongdoing by applicants, grantees, or contractors perpetrating criminal activity against our programs and operations. When an OI investigation proves to have merit for potential Federal criminal prosecution for fraud, OI special agents then refer the case to the appropriate United States Attorney's Office. Ultimately, the decision of whether to prosecute any case of potential fraud rests with the U.S. Attorney's Office.

   With regard to the beneficiary identified in Case Study No. 2, OIG's investigation of potential fraud is ongoing, and we will allow that process to work.

[1] See Sections 208(a)(1)-(8) and 1632(a)(1)-(4) of the Act, 42 U.S.C. §§ 408(a)(1)-(8) and 1383a(a)(1)-(4).

[2] *United States v. Phythian*, 529 F.3d 807, 812 (8th Cir. 2008); *United States v. Phillips*, 600 F.2d 535, 536 (5th Cir. 1979).

[3] *United States v. Lichenstein*, 610 F.2d 1272, 1277 (5th Cir. 1980).

3. **When should the individual in Case Study No. 2 have reported that she returned to work?**

   Beneficiaries should report at the point they return to work and subsequently whenever a change in work activity occurs.

4. **SSA states it performs computer matching with IRS data on reported earnings. The individual in Case Study No. 2 returned to work in 2003, so for at least six years, there should have been a match with IRS data. Please explain how this beneficiary's earnings went unnoticed for six years.**

   Please refer to our response to Question 1.

5. **The TSA worker in Case Study No. 2 requested that SSA not contact her employer.**

   a. **When a disability beneficiary states that they do not want SSA to contact their employer - as the TSA agent did here - why would SSA comply with such a request?**

      Please refer to our response to Question 1.

   b. **Why would SSA not try to determine if the individual was working?**

      Please refer to our response to Question 1.

   c. **Would her lack of response regarding her work report be a red flag that this person may be defrauding the system?**

      Not necessarily. A beneficiary may not want his or her employer to know about his or her disability status for fear of being stigmatized or losing the employment opportunity. In addition, a beneficiary may have practical reasons that explain his or her reluctance. For example, the beneficiary may not have proof of earnings readily available, or may be incapacitated due to illness or even confined in a hospital. The beneficiary may not have received our request for earnings information because we have incorrect address information, or the beneficiary may not understand the request due to his or her impairment. We make every effort to treat our beneficiaries with respect and do not automatically assume that they intend to defraud the government.

   d. **Why is a person that refuses to comply with rules of the disability program allowed to remain on the rolls for years and continue to receive disability payments?**

      As explained in our response to Question 1, we do not have sufficient resources to handle all of this work timely. We agree that we should have acted more quickly.

e. **Why did SSA not perform a medical CDR on this beneficiary?**

The Act prohibits us from initiating a medical CDR based solely on work activity for any beneficiary who has been receiving benefits for at least 24 months. We initiated a regularly scheduled medical CDR in January 2007. The beneficiary did not respond to several requests for information, and we subsequently suspended her benefits for not cooperating with us.

6. **There does not appear to be any consequences for getting caught defrauding SSA. What were the consequences, if any, for the TSA employee when GAO caught her?**

Our OIG is currently investigating these allegations for possible fraud. If OIG finds *prima facie* evidence of fraud, it will refer the case to the Department of Justice for possible criminal prosecution.

7. **For Case Study No. 14, SSA placed the beneficiary on a repayment plan that required the individual to pay $20 per month for 130 years, beyond the individual's life expectancy.**

a. **How is this effective means of collecting payments?**

When a person is not receiving benefits and cannot refund the full overpayment in a single payment, we attempt to negotiate a repayment schedule that would permit recovery in one year. If that is not possible, we try to negotiate a schedule that would permit recovery within 36 months. If we cannot get an agreement that permits recovery within 36 months, we negotiate a schedule the debtor can manage, but at least $10 per month. We do this because any agreement to repay benefits is more productive than no agreement at all. An agreement such as this one, though, is generally our last resort.

If a debtor defaults on the agreement, we refer qualified debts to the Department of the Treasury for collection via the Treasury Offset Program (TOP), where Treasury may recover the debt through forced collection methods such as Tax Refund Offset (TRO) and Federal Salary Offset (FSO).

In this case, the debtor failed to make two monthly payments, and we referred the debtor to Treasury in April 2010. In June, we received more than $4,000 via TRO. This debt is also subject to collection through FSO. We believe that Treasury has issued an FSO notice, which gives the debtor 30 days to protest the offset.

After the due process period, if the debtor has no other higher priority Federal debt, we will begin to collect the debt by offsetting 15 percent of the debtor's disposable pay. Recovery via FSO does not prevent Treasury from applying future TRO and other forced collections methods.

b. **How often do unrealistic payments plans like this occur?**

We do not collect this type of data, but extended payment agreements such as this one are generally our last resort.

c. **Would this individual be able to return to the rolls, even if they were still repaying their debt?**

Yes. Debt does not preclude entitlement to benefits; however, if a person with an overpayment returns to our rolls, we will recover the outstanding amount.

d. **How can SSA guarantee that in the future people like this do not receive both federal disability payments and federal wages? Please explain.**

In certain situations, a person can legitimately receive both disability benefits and Federal wages. In fact, Congress has worked with us to encourage beneficiaries to return to work. When we learn that a beneficiary has wages, we verify what the wages represent and when they were earned, determine whether the beneficiary continues to be entitled to benefits, and provide due process prior to stopping benefits. In addition, during the appeal period, a beneficiary can continue to receive benefit payments after we have determined that he or she no longer meets eligibility requirements if he or she timely appeals that decision.

e. **Given that recipients of DI and SSI are individuals that face serious medical and financial challenges, is it realistic to think that the government will ever get money it overpays to recipients back once it goes out the door?**

Yes. In FY 2009, we collected $1.94 billion in DI and SSI program debt using a combination of internal and external collection methods. Historically, we recover 60 percent of overpayments over 10 years.

8. **There is a great deal of information available to SSA that collect on federal employees. How can the American taxpayer trust that SSA is able to properly police the disability program when it cannot even guarantee that federal employees are not taking advantage of the disability programs? Please explain.**

We take seriously our responsibility to protect and carefully manage the resources and assets entrusted to us. Overall, our employees are vigilant and effective stewards of our programs, and we believe the public's confidence in us is well founded. While the GAO went to some effort to identify a number of the most egregious cases in which people appear to have been inappropriately paid benefits, these cases are atypical and their number is small when compared to the number of claims we handle and benefits we pay.

As I testified at the hearing, we paid over $2.4 trillion to retirement and survivors beneficiaries during fiscal years (FY) 2005-2009. In that same period, we paid $490.6 billion to DI beneficiaries and $218.6 billion to SSI recipients. The overwhelming percentage of payments was accurate. In FY 2009, 99.63 percent of all OASDI payments

were free of an overpayment, and 99.91 percent were free of an underpayment. In the SSI program, 91.6 percent of all payments were free of an overpayment, and 98.4 percent were free of an underpayment.

Clearly, because we pay out such huge dollar amounts, even a small error rate can result in significant incorrectly paid dollars. Therefore, even though our accuracy is high, we are working to make it better, particularly in the SSI program, and we are working to reduce improper payments on a number of fronts. In coordination with our OIG, we established 21 Cooperative Disability Investigation units across the country to investigate issues of potential fraud, resulting in $1.4 billion in savings to our disability programs since FY 1998. We match earnings data with the IRS to help ensure that we properly evaluate work done by beneficiaries with disabilities, and we obtain over 36 percent of death notices electronically from States and other jurisdictions. In FY 2011, we plan to conduct 360,000 full medical CDRs and 2,422,000 SSI redeterminations. These two programs have high savings-to-cost ratios. Realistically though, given the complexity of our programs and requirements like providing due process, there will always be some incorrect payments. Our employees work hard to prevent errors and, given adequate resources, I am confident that they will continue to improve in this area.

9. **What confidence can Congress place in SSA to catch individuals employed by private companies when it cannot properly police federal employees? Please explain.**

Please see our response to Question 8, above.

10. **GAO investigators found that each of the 1,500 people they flagged for possible improper payments were both: (1) working for 12 months or longer and (2) collecting a disability check. Normally, these two things should not happen.**

As explained above, in certain situations, it is entirely appropriate for beneficiaries to both work and receive disability benefits. We provided information prior to and during the hearing to both subcommittee staff and GAO investigators regarding the work incentives within both the DI and SSI programs that allow some earnings to be disregarded from countable income when we make a determination of SGA. In addition, GAO looked for the most egregious cases and agrees that the cases it found are not representative.

a. **Can you give a plausible explanation for why these cases *may not* have been improper?**

The Act contains work incentive provisions that permit beneficiaries to remain eligible for SSDI or SSI benefits even when they work. These work incentives (which are described in more detail in response to Question 10b, below) may lower the amount of countable income of an SSDI beneficiary below the SGA level and reduce an SSI recipient's countable income to a level where the earnings do not effect eligibility or reduce the benefit amount.

b. **What work incentive(s) allows an individual to work more than a year at a full time job and still receive full disability payments?**

We have previously provided subcommittee staff and GAO investigators with materials explaining how a beneficiary may work while continuing to receive disability benefits. We have excerpted those materials below:

SSDI Work Incentives

- Trial Work Period (TWP): An SSDI beneficiary can test his or her ability to work without affecting benefits. If the beneficiary works for 9 months and earns over $720 a month (in 2010) within a rolling 60-month period, we consider that the TWP is completed.
- Impairment-related work expenses: We will deduct from earnings the costs for certain items and services that are related to the disability and are needed in order to work.
- Subsidies and special conditions: Supports received on the job that result in the person receiving more pay than the actual value of the services performed.
- Unsuccessful work attempts: We disregard earnings from work attempts of 6 months or less that were stopped due to the impairment.

SSI Work Incentives

- Impairment-related work expenses – similar to SSDI above.
- Blind work expenses: For SSI beneficiaries receiving benefits based on blindness, we exclude any earnings that are used to meet expenses needed to earn that income.
- Student earned income exclusion: We do not count up to $1,640 (in 2010) of monthly earnings (up to a yearly maximum of $6,600 in 2010) of a student under age 22.
- Plan to achieve self-support: We do not count any earnings an SSI beneficiary sets aside toward an approved plan.

c. **Now that SSA has the list of the 1,500 federal workers located by GAO, in SSA's analysis of these individuals, did SSA find that *any* of the 1,500 cases uncovered by GAO were the result of fraud? Please explain.**

We identify and refer cases where fraud may be involved but we do not determine whether a beneficiary committed fraud. We recently received the list of 1,500 employees and have not yet completed our analysis. We will refer any potentially fraudulent activities to our Inspector General for further investigation and action.

d. **Does SSA check federal salary data to determine if individuals are receiving disability payments improperly or fraudulently? Why or why not? Please explain.**

We review the earnings posted by all employers including the Federal government and self-employed persons through our annual match with IRS data.

Although GAO obtained employment data for other Federal agencies, the Privacy Act limits our access to this information. For us to obtain the same level of employment data, in accordance with the Privacy Act, we would need to establish a data sharing agreement with each individual Federal department or agency. Even to use our own employment data to match employment data against our beneficiary data, the computer matching provisions of the Privacy Act require us to establish a formal agreement with ourselves.

We are pursuing a matching agreement to review our own payroll data against our disability rolls. Additionally, we are considering the cost-effectiveness of implementing and managing potentially hundreds of matching agreements covering payroll data with other Federal agencies.

e. **Does SSA require federal agencies to report when an individual on Social security disability is hired? Why or why not? Please explain.**

We do not have legal authority to require that Federal agencies report when they hire a Social Security beneficiary. The Americans with Disabilities Act (ADA) limits what employers may ask employees regarding their medical condition and disabilities. Questions regarding an employee's status as a disability beneficiary could be wrongly construed as seeking information regarding the employee's disability.

11. According to GAO, an employee at your own agency was working full-time and also receiving disability benefits. SSA began providing benefits to the individual in 2003 for mood disorders and osteoarthrosis. The individual began working for SSA in 2003 and did not notify SSA. SSA then increased her benefits based on her wages earned at SSA in 2007 and also sent her a $250 stimulus check.

a. **What was your response when you first learned that someone at your own agency was getting disability payments and had been working at SSA for more than 12 months?**

Our first response was to investigate the employee's situation to determine if she properly reported her work activity, and was participating or had participated in one of the work incentives described above in response to Question 10b. As indicated above, the Act provides a number of incentives for disability beneficiaries to return to work.

After evaluating this case, we determined that the employee did not properly notify us of her work activity, but that she qualified for the return-to-work incentives set out in the Act. The employee participated in a nine-month TWP. During her TWP, while the

employee tested her ability to work, we still considered her disabled and eligible for SSDI benefit payments.

The employee's TWP ended in August 2008, after which she qualified for a three-month "grace period," during which SSDI beneficiaries receive benefit payments regardless of work or earnings at the SGA level. This "grace period" then begins the 36-month extended period of eligibility (EPE) that began in September 2008. During the EPE, the employee is not entitled to receive SSDI benefits for any month she works over the SGA level. In this employee's case, the EPE will run through August 2011. If the employee is working and has earnings at the SGA level at the end of her EPE, she will no longer be entitled to SSDI benefits. If she is not working at that time and is still medically disabled, she may be entitled to SSDI benefits.

Although we were disappointed that this employee did not report her work activity as the law requires, her case illustrates the challenges beneficiaries who return to work encounter. On the positive side, her case shows how the work initiatives established by Congress can help disability beneficiaries to return to the work force while providing a safety net for our most vulnerable population.

b. **How is it possible that this could even happen?**

Please see the response to Question 11a, above.

c. **How has SSA dealt with the individual in Case Study No. 8? Was this person removed from the disability program?**

The employee remains medically disabled. As explained in response to Question 11a above, her benefit payments are in suspense status while she completes her EPE, which will run through August 2011. During this time, we will continue to evaluate her work, earnings, and her benefit entitlement.

Additionally, we determined that we overpaid the employee by approximately $5,000, and the employee agreed to an accelerated 13-month repayment schedule.

We emphasize that we cannot assume that an employee with an overpayment has violated the law. We must examine each case on its own merits.

d. **Is the individual still working at SSA, or anywhere else in the federal government?**

Yes, she is still working with us.

e. **If she no longer works at SSA, is she eligible to receive disability payments again?**

Please see our response to Question 11a, above.

f. **Is the individual in Case Study No. 8 currently receiving disability payments?**

No. As described in response to Question 11a, above, we have suspended her payments, in accordance with the terms of the EPE.

g. **Does SSA check to see if an individual is receiving disability payments before it hires that individual? If not, should it?**

We do not ask applicants if they are receiving disability payments. As mentioned above, the ADA and its implementing regulations limit what employers may ask applicants regarding their medical disabilities. Making generalized inquiries of applicants' disabled status could lead to claims that we are conducting medical inquiries of applicants in violation of the ADA.

At employee orientation, we do inform all new hires that if they are receiving disability benefits, they should report their work activity to us.

h. **Has SSA found other individuals working at SSA and receiving disability payments, whether proper, improper, or fraudulent?**

Yes, we know that some of our employees are receiving disability benefits. As mentioned above, we are exploring whether a data match with our beneficiary records and Federal payroll records might help us detect unreported earnings earlier, trigger work continuing disability reviews sooner, and reduce overpayments.

12. **GAO found that for fiscal years 2004-2008, the debt owed to SSA for overpayments of DI and SSI benefits reached $10.7 billion. In SSA's comments to the GAO Report, it mentions a "number of proactive actions" SSA is taking to reduce improper payments in the programs. However, SSA defended its administration of the programs by stating that "overpayments are unavoidable because even if the beneficiary appears to be working over SGA, we cannot stop benefits until we have completed our development, made our determination, and provided due process."**

a. **Does the current system in place guarantee overpayments to individuals leaving the DI or SSI?**

No. Some beneficiaries timely report their earnings and have no overpayment. In many cases, however, overpayments are unavoidable. Delayed earnings reporting, our complex work incentives rules, and due process requirements often lead to overpayments.

Furthermore, beneficiaries have the statutory right to continue to receive benefits during our SGA reviews. If we continue paying benefits while reviewing a person's SGA, we may overpay the beneficiary, but we attempt to recover these overpayments.

b. **Does SSA find it acceptable that a government-run program guarantees overpayments?**

No. However, as explained above, some overpayments are unavoidable because of the complexity of our disability programs, and the limitations that many of our beneficiaries face. We strive for continued improvement in this area, but we must act within the law as Congress created it.

Also, please note that we make accurate benefit payments in the overwhelming majority of cases. Less than 2 percent of the approximately $115 billion in Social Security disability payments made in FY 2009 were overpayments. We recognize that we must improve our overpayment reduction efforts. As stated in response to Question 1, our priority has been to focus on responding to the recent unprecedented influx of disability claims.

c. **What alternatives exist to the current system, which requires SSA to attempt to collect improper payments after it makes them?**

Our Access to Financial Institutions (AFI) project automates the verification of bank assets held by SSI applicants and beneficiaries. The President's FY 2011 budget includes funding to continue nationwide rollout of this important project.

We are also exploring initiatives to simplify our SSDI work incentive provisions. The likelihood of overpayments would substantially decrease if such provisions were easier for working beneficiaries to comprehend and had fewer complexities for us to administer.

We also see opportunities to make it easier for beneficiaries to report earnings to us, and for us to verify earnings and quickly adjust benefit amounts. In response to Question 14, below, we describe our efforts to expand telephone reporting, to create an option for internet reporting, and to take other efforts aimed at improving the process. We also are exploring ways to make greater use of earnings data to identify work activity sooner and to prevent beneficiaries from accumulating large overpayments.

We request your support in these endeavors and welcome future collaborative efforts on any legislative proposals that could help us simplify our programs.

13. CBO recently estimated that the Disability Insurance Trust Fund would be exhausted by 2018.

a. **What effect do these overpayments have on the Disability Insurance Trust Fund?**

Annual overpayments in the DI program for FY 2009 were $1.7 billion—less than 1.5 percent of DI program outlays. In addition, we recover about 60 percent of DI overpayments over 10 years.

b. **What does SSA propose to deal with the exhaustion of the Disability Insurance Trust Fund?**

On solvency-related matters, such as your question, we defer to the Secretary of the Treasury, the Managing Trustee of the Social Security trust funds.

14. Mr. Astrue states in his written testimony that "the complexity of [SSA's] disability programs leads to overpayments."

a. **Should the process be changed so that overpayments are eliminated?**

Congress should consider ways to reduce overpayments by amending the current law. We have been working hard to do what we can to reduce overpayments by administrative action, but most of the possible significant improvements require statutory changes.

b. **If so, what process(es) does SSA suggest be implemented to remove, or at least limit, overpayments?**

We are examining our processes governing return to work, work CDRs, and earnings reporting, as we believe that these areas will provide us the most benefit in limiting overpayments.

We convened a national work CDR workgroup in January 2010 to discuss related work and administrative issues, consider options, and recommend improvements to the processing of work CDRs. Some of the recommendations from the workgroup and other sources that we put into place are:

- Dedicated staff to target the oldest cases—initially, cases over 365 days old, then a gradual reduction of the age threshold;
- Prioritized earnings alerts by amount of earnings and work cases with highest earnings to minimize overpayments;
- Improved communication between operational components; and
- Allocated additional staff resources to conduct work CDRs.

To improve the quality and timeliness of self-reporting earnings data, we recently implemented an automated monthly telephone wage reporting process to make it simple and more convenient for SSI recipients to report wages. The process uses both touch-tone and voice recognition technology to collect wage reports and automatically enters the wage data into the SSI system. Telephone wage reporting is more efficient than providing wage information through the mail or when visiting a field office, which requires manual entry of the earnings report. The telephone wage reporting system's dollar accuracy is high. We plan to extend this telephone wage reporting process to SSDI beneficiaries and to investigate methods to automate the posting of the wage information to SSDI records.

We also plan to establish an Internet website for disability beneficiaries to report their wages quickly and easily. Based on the results of electronic reporting through the SSI telephone wage reporting process, we expect these initiatives to help us reduce SSDI overpayments resulting from late reporting of earnings.

We are developing a statistical predictive model that identifies beneficiaries who are at risk of receiving high earnings-related overpayments. We plan to begin testing this model this fall. The predictive model will prioritize the alerts that we receive based on a variety of case characteristics, which allows us to prioritize our staff resources for enforcement actions, thereby reducing work-related overpayments.

We are developing a legislative proposal to simplify the work incentive provisions in the SSDI program. We will provide our legislative recommendations to you as soon as the Administration approves them. We look forward to working with Congress on improving the SSDI program to make it easier to understand for beneficiaries and to help us improve our stewardship of the program.

We would be happy to work with your staff to explore other ideas ways to prevent or limit overpayments.

15. What percentage of overpayments in the DI and SSI programs are recovered annually? Please provide data for at least the past five years.

We have listed in the table below overpayment recoveries as a percentage of our available debt for the past five years. Available debt is comprised of existing debt carried forward from prior years plus newly detected overpayments and any reestablished overpayments.

Recoveries as a Percent (%) of Available Debt					
Fiscal Year	**2005**	**2006**	**2007**	**2008**	**2009**
DI Program	10.5%	11.6%	11.9%	12.8%	13.0%
SSI Program	14.2%	13.9%	13.8%	13.7%	13.0%
TOTAL	12.7%	12.9%	13.0%	13.3%	13.0%

16. The $10.7 billion in overpayments listed in Appendix III of the GAO report excludes "collections, waivers, and write-offs in each fiscal year."

a. **Does this mean that improper payments are actually much higher? If so, please provide the amount that includes "collections, waivers, and write-offs."**

We exclude collections, write-offs, and waivers from the total amount of overpayments because the Act allows us to forgive or eliminate these debts. If we did not exclude them, the total amount of overpayments at the end of FY 2008 would be approximately $13.4 billion.

b. **Exactly how much debt is waived or written off by SSA each year? Please provide data for at least the past five years.**

The table below shows our waivers and write-offs in the DI and SSI programs for the past five FYs.

Waivers ($ in millions)					
Fiscal Year	**2005**	**2006**	**2007**	**2008**	**2009**
DI Program	$227.5	$286.6	$240.1	$241.8	$249.5
SSI Program	$154.0	$149.0	$123.3	$121.3	$130.2
Write-offs ($ in millions)					
DI Program	$133.8	$209.2	$223.3	$262.2	$238.8
SSI Program	$209.8	$337.2	$261.7	$231.4	$260.8
Waivers & Write-offs ($ in millions)					
DI Program	$361.3	$495.8	$463.4	$504.0	$488.3
SSI Program	$363.8	$486.2	$385.0	$352.7	$391.0
TOTAL	**$725.1**	**$982.0**	**$848.4**	**$856.7**	**$879.3**

17. According to SSA, for four of the 20 case studies, the beneficiary affirmatively contacted SSA and requested payments be stopped, but payments continued.

a. **Can an SSA caseworker immediately stop benefit payments when a beneficiary requests disability payments cease?**

Yes. A beneficiary may request to suspend benefits to avoid an overpayment. To suspend benefits, we must obtain a signed statement from the beneficiary documenting the request.

b. **If it is a due process issue, isn't a voluntary request from the beneficiary for payments to stop enough? If not, what is required?**

If a beneficiary requests to have benefits suspended, we do not need to send a due process notice.

c. **Should SSA be able to suspend an individual's disability benefits upon a request by the beneficiary?**

Please see our response to Question 17a, above.

18. In your response to GAO regarding the 20 investigated cases, you state "our methods are working....we had already detected overpayments for half of the 20 cases handpicked for this review. Our existing process identified these cases and we had already computed overpayment amounts." Do you believe identifying overpayments years later that result in tens of thousands of dollars a system that "worked?" Please explain.

We share your concerns about the length of time we take to process these overpayments, and we are looking into ways to detect earnings and complete work CDRs in a timelier manner given the constraints of annual IRS reporting. Nonetheless, our computer matches with IRS do detect unreported earnings. Furthermore, as mentioned above, we continue to evaluate our work processes and have taken actions to improve the timeliness and accuracy of our work CDR cases, and self-reported earnings data.

19. In several of the cases highlighted by the GAO report, SSA sent notice to the beneficiary that they were no longer eligible to receive benefit payments, but the payments still continued resulting in tens of thousands of dollars in overpayments. Why did payments continue when SSA said they would stop?

Payments continued because some of our caseworkers did not follow proper procedures.

20. You state in your written testimony that "[b]eneficiaries who fail to report work activities are a significant source of errors...." Further, SSA acknowledges that beneficiaries rarely self-report work or medical improvement for fear of losing their benefits. Yet, your testimony makes much of the new ways SSA is developing for beneficiaries to self-report through an automated telephone wage reporting system and a website.

We did not say that beneficiaries rarely report work. Rather, beneficiaries who fail to report work activities are a significant source of errors in calculating SGA, which leads to overpayments.

a. **Why is SSA spending funds to develop these programs when it acknowledges that beneficiaries do not use them?**

We are developing these programs because they help us reduce overpayments. Based upon a previous study of the SSI program, the dollar accuracy of reported wages using telephone wage reporting was 92.2 percent, compared with the 75.5 percent dollar accuracy of the wage estimates received through other means. We anticipate similar success in reducing SSDI overpayments. We hope to increase

reporting compliance by providing SSDI beneficiaries with an easier and more efficient means of reporting their wages, thus reducing improper payments due to late reporting.

b. **Is self-reporting the proper way to ensure against overpayment and fraud?**

Timely self-reporting of work by beneficiaries is the best way to ensure against overpayments. All other methods of detecting unreported earnings necessarily involve a lag between the time the work activity was performed and when we learn of the earnings, because it takes us time to obtain this information from other sources.

c. **How can SSA rely on beneficiaries to self-report work and medical improvement when beneficiaries rarely self-report for fear of losing their benefits?**

We utilize beneficiary self-reporting because this is the most easily obtainable source of information we have. We also recognize that many beneficiaries are not intentionally attempting to mislead us. Our work rules are complex and difficult to understand. Therefore, we do not rely solely on beneficiary self-reporting in reporting earnings or medical improvement. We use information reported by beneficiaries, information from data matches and secondary sources, and our CDR process to verify the data provided by the beneficiary.

We are reviewing our publications about disability and work, and we will clarify our instructions about reporting responsibilities. We will also provide additional information about when, where, and how to report work.

We do not ask beneficiaries to make a self-determination about disability, and we do not rely solely on self-reporting to detect potential improper payments or to ascertain continued program eligibility.

As we explained to your staff at our July 12, 2010 briefing on medical CDRs, the CDR mailer form is designed as a screening device to avoid unproductive and costly full medical reviews. We use the CDR mailer form in conjunction with our predictive CDR models to confirm those cases for which it is not cost effective to initiate a full medical CDR due to the extremely low likelihood of medical improvement. In addition, we select a large number of mailer cases for integrity review where we perform a full medical review even though the predictive models and mailer responses indicate that a deferral would be proper.

Statistical analysis on hundreds of thousands of CDR mailers and our large integrity samples indicate that our predictive analytics are extremely effective in screening out unproductive medical CDRs. Our research shows that when disabled beneficiaries medically improve, rather than giving us false answers, they simply fail to complete and return the CDR mailer. When the beneficiary fails to return a complete CDR mailer, we automatically initiate a full medical review CDR.

21. What are the root causes for the agency's high improper payment amounts and what needs to be done to remedy these causes?

The major causes of OASDI improper payments are SGA, government pension offset, earnings errors, computation errors, and workers' compensation offset. For SSI, the major causes are financial accounts, wages, living arrangements, and in-kind support and maintenance. We have a number of initiatives in place to address these issues.

For OASDI, our initiatives include:

- Utilizing the Office of Child Support Enforcement (OCSE) New Hire Database on a query basis to detect unreported work.
- Using the eWork system to track and prioritize the processing of work CDRs.
- Expanding the use of predictive modeling to track and prioritize the processing of work CDRs.
- Concentrating review on error-prone cases involving workers' compensation.
- Implementing the Earnings Alert Project to help identify earnings mistakenly omitted from a beneficiary's record.

For SSI, our initiatives include:

- Implementing a process that will enable electronic verification of amounts held in an SSI applicants'/recipients' bank accounts and detect the presence of liquid resources in undisclosed accounts.
- Significantly increasing the number of SSI redeterminations performed each year.
- Using *all* available information regarding recipient earnings, including information available from OCSE and other sources.
- Utilizing a new wage-reporting system that will allow working SSI recipients to report earnings to us by phone.

Our response to Senator Levin's Question 1 describes a number of ways we are trying to expand our data matching processes.

22. The GAO determined that 62,000 individuals in 12 states were issued CDLs after SSA determined the individual was disabled. Given the fact that federal regulations require individuals with active CDLs to go through a medical exam every two years, should SSA check with states to see if individuals on Social Security disability have active CDLs?

a. **Do you think that it would be useful for the SSA to do a computer match to determine if a disability recipient is either driving commercially or opening a transportation business? Please explain.**

Based on the GAO report, we do not think that it would be useful to do a computer match to determine if a disability recipient has a CDL or is listed as owner of a transportation business. A person with a mental impairment or a non-obvious physical impairment might be able to obtain a CDL, while still being disabled under the Act. GAO looked at

the possibility of conducting such matches but did not recommend doing so in its report. We discussed this issue with GAO staff, and they agreed that these data do not contain earnings information and are not dispositive proof of fraud.

The GAO report acknowledges that merely holding a CDL does not mean a beneficiary is driving commercially or engaging in SGA. Further, beneficiaries shown as owning a transportation business may have only a passive interest in the business. GAO acknowledges that we would have to investigate separately each instance where a beneficiary has a CDL and thus does not recommend such a computer match.

b. **How is it possible for a person to be considered medically competent to hold a CDL, yet unable to perform "any job in the national economy (the SSA disability standard)?"**

The medical criteria and documentation required for a CDL are different from that required to meet the definition of disability. We evaluate a person's ability to perform SGA and consider impairment related work expenses, subsidies and special conditions, and other information when evaluating whether a person meets our definition of disability. We provide additional information about SGA in our response to Question 23.

23. Assuming that it met all financial requirements, would driving a commercial vehicle or opening a transportation business constitute Substantial Gainful Activity (SGA)?

The determination of SGA is a complex process. Driving a vehicle for a day or two a month does not necessarily constitute SGA. Signing the documents to open a business does not necessarily constitute SGA. Below is information regarding the SGA determination process that we included in several briefings with subcommittee staff and shared the information with GAO investigators:

SGA

SGA means the performance of significant physical and/or mental activities in work for pay or profit or in work of a type generally performed for pay or profit, regardless of the legality of the work.

- Work may be "substantial" even if performed on a part-time basis, or if the person does less, is paid less, or has less responsibility than in previous work.

- Work is "gainful" if it is the kind of work usually done for pay, whether in cash or in kind, or for profit, whether or not a profit is realized.

We use SGA as a factor to determine initial eligibility for both Social Security Disability Insurance (SSDI) and SSI, as well as to decide if disability continues for SSDI after completion of the trial work period (TWP). We do not use SGA for initial eligibility to SSI based on blindness.

Evaluation of SGA

After we determine monthly gross earnings, we apply applicable work incentives. We are only concerned with income that represents the actual value of work performed as a result of the person's own productivity. We then use the SGA earnings guidelines to evaluate the countable earnings.

Generally, countable earnings averaging over $1,000 a month (in 2010) demonstrate the ability to perform SGA. For blind persons, countable earnings averaging over $1,640 a month (in 2010) generally demonstrate SGA for SSDI.

We have different SGA development criteria for employed and self-employed beneficiaries:

- For employed beneficiaries, we begin with gross earnings and apply any applicable deductions (e.g., subsidy, impairment related work expense, etc.) to obtain the countable income that we compare to the earnings guidelines.

- For self-employed beneficiaries, we evaluate work activity using three tests. Has the beneficiary rendered services significant to the operation of the business and does he or she receive significant income from that business because of those services? If not, we then determine if the beneficiary's hours, skills, and duties are comparable to individuals in the community engaged in similar activities. If we do not find SGA from tests 1 or 2, we consider test 3, which is a determination of worth of work. Under test 3, if a beneficiary's work activity is clearly worth more than the SGA earnings guidelines, we determine that the work is SGA.

For both employed and self-employed beneficiaries who have received SSDI benefits for at least 24 months, we apply only the countable income test. Under the countable income test, we compare the beneficiary's countable earnings (gross earnings minus any applicable work incentives) to the earnings guidelines. If the countable earnings are above the SGA amount, we find that the beneficiary has engaged in SGA.

Benefit Eligibility Based on SGA

If an SSDI or SSI claimant's work is over SGA, the definition of disability is not met and benefits are denied.

When an SSDI beneficiary returns to work, he or she will receive full, unreduced benefits for at least nine months of work and earnings. This is the TWP. After the TWP, we will evaluate earnings for SGA to determine if disability continues. This is a work continuing disability review (CDR).

When an SSI beneficiary returns to work, we are not concerned with SGA. We count income and earnings when received (after allowable deductions) to determine the monthly payment amount. The countable income is subtracted from the Federal Benefit Rate

($674 in 2010) to calculate the monthly payment amount. An SSI beneficiary may go in and out of pay status based on countable income. An SSI beneficiary whose payment is reduced to zero because of earnings will retain eligibility for SSI and Medicaid provided his or her disability continues and earnings are below a State threshold amount. State thresholds vary between a low of $23,981 in Alabama to a high of $54,815 in Connecticut.

24. States would likely be interested in the fact that an individual holding a CDL applied for disability. For example, in Case No. 7, the Texas-based beneficiary claimed to have a back disorder and be "on pain medication for life." Yet, he has a CDL and had two roadside inspections in 2008 in Florida and Texas. Would it be possible for SSA to exchange information with states and collect driver's license information at the time a person applied for disability?

As mentioned above, the Privacy Act provides that Federal agencies may collect and maintain information about persons only when it is relevant and necessary to accomplish a purpose of the agency required by statute or by Executive Order of the President. (5 U.S.C. § 552a(e)(1)) Therefore, we cannot collect driver's license information (including commercial license information) on ***all*** disability applicants. For most of them, this information would not be relevant and necessary to determining their entitlement to benefits.

We are permitted to collect from third parties any information that is relevant or necessary to assist us in determining a person's entitlement to or continued entitlement to benefits when the information is needed 1) to establish the validity of evidence or, 2) to verify the accuracy of information presented by a claimant or beneficiary. It may be possible under this provision to seek additional information from State motor vehicle agencies (MVAs) in individual situations in which the specific disability allegation warrants it.

There are also some general privacy concerns related to sharing our disability data with MVAs. The Privacy Act permits us to disclose a record only when the use of the record is compatible with the purpose for which it was collected. Thus, for us to share a disability record with DMVs, the DMVs must have a similar use for the data as we do when we collect it. We may share disability records with another agency only if its mission is similar to our health and income maintenance program purpose.

25. Please explain why SSA designed the AERO computer system to automatically increase a beneficiary's wages, but did not equip the same system to acknowledge the beneficiary is working?

The Automated Earnings Reappraisal Operation (AERO) is designed to pay an SSDI beneficiary based on that beneficiary's earnings record, in accordance with the provisions of the Act. We run the AERO twice a year using data from the Master Earnings File (MEF). The AERO detects the presence of new earnings and calculates new monthly benefit amounts.

A related operation, the Earnings Enforcement Operation, reviews a beneficiary's earnings record and identifies disabled beneficiaries who have earnings during a period of disability.

This system produces alerts for work CDRs to determine whether these beneficiaries remain entitled to payment. We run the Earnings Enforcement Operation three times a year using data from the MEF (i.e., the same source data used by the AERO).

Prior to 1995, the AERO computed appropriate payment increases for disabled beneficiaries but held the increase until a technician took action to release it. At that time, we changed the AERO to allow release of the increase immediately because studies showed that a majority of disabled beneficiaries were properly due the increased benefits and would have otherwise waited (often for many months) to receive the benefit increase.

We are considering what business process and system changes we can make to the AERO and the Earning Enforcement Operation systems to support timely increases in benefits in accordance with the Act while ensuring that we more timely identify and handle work CDR alerts.

26. According to the latest SSA data, 31.1 percent of individuals (the largest diagnostic group) are on disability for mental disorders (excluding the developmentally disabled).

a. **Does SSA monitor these individuals differently than individuals with physical disabilities?**

Yes. As we discussed in our meeting with your staff on July 12, 2010, a beneficiary's primary impairment is only one of many characteristics we consider in monitoring a case, along with age, length of time on the rolls, work history, etc.

As described above, we have developed predictive models to determine when to initiate a medical CDR. We base these models on several million observations of known CDR outcomes for medical CDRs completed since FY 1998. Given the historical outcomes, we know that certain impairments are more likely to improve medically. For example, we know that beneficiaries with mental retardation are less likely to improve medically than beneficiaries with other mental impairments. Our models recognize this fact and identify these beneficiaries for full medical CDRs less frequently. In contrast, beneficiaries with both psychotic and non-psychotic mental impairments are more likely to be subject to a full medical review than to a CDR mailer. They are also subject to review more frequently.

b. **If not, should SSA monitor these individuals differently? Please explain.**

Please see our response to 26a above.

27. SSA's methods for determining if an individual returned to work and suspension of payments is conducting CDRs for DI and redeterminations for SSI. However, for two of the cases in the GAO report (Nos. 1 and 12), SSA completed work CDRs, determined payments should stop, but failed to stop the payments. Why did this happen? Is this a systemic problem?

Our caseworkers did not follow proper procedure in these two cases, but these cases are not indicative of how we routinely process hundreds of thousands of work issue cases each year. GAO did not select these cases from a representative sample; rather, it handpicked cases that had errors.

28. In your comments to the GAO Report, you state that you "would have identified the remaining 10 cases where IRS reported earnings for those beneficiaries."

a. **Once a beneficiary starts working, how long does it take for SSA to obtain that information from IRS on this employment?**

It can take up to 18 months.

b. **Are there more current forms of data to use?**

We use the most cost effective means currently available to us. As explained in the response to Senator Levin's Question 1, we are investigating new ways to expand our data matching processes.

c. **Would the federal payroll data be more current?**

Yes.

d. **SSA states that it uses the National Directory of New Hires, which comes out quarterly, to detect overpayments for the SSI program. At the hearing, the Commissioner stated that it is not cost effective. Please provide this analysis.**

In August 2010, we provided your staff with our report on the possible SSDI data match. We are enclosing a copy of that report, which includes the cost benefit analysis (CBA). In addition, we submitted the Executive Summary for the record after the hearing.

e. **Even if using the National Directory of New Hires only saved some money, does SSA not feel that saving taxpayer funds in improper payments, maintaining the integrity of the programs, and complying with the President's directive to eliminate overpayments justify the use of this database?**

We take our stewardship responsibilities very seriously. We have limited resources to balance between handling the surging number of benefit applications, completing the additional responsibilities that Congress has given us, and increasing our program integrity work. Current law gives us no choice but to look for the most cost-effective program integrity opportunities.

We already match the NDNH against our SSI rolls because income affects the amount of monthly SSI payments. The return on investment (ROI) for the SSI match is about $6.70 for every dollar spent. In addition, our field offices can access OCSE data online. Our field office employees can use this information as part of their evaluation of beneficiaries' work activity. We estimate that the online availability of OCSE data provides an ROI of about $2.70 for every dollar spent.

The CBA for conducting an OCSE wage match for SSDI cases shows that we would save only $1.40 for every dollar spent. On the other hand, CDRs and SSI redeterminations provide an ROI that is five to ten times higher than the OCSE match does. Annually, we handle millions of CDRs and redeterminations, and this year we have increased these program integrity activities. It would not be cost-effective or responsible management of taxpayer dollars, to redirect our limited resources away from conducting more CDRs and redeterminatons to implement an OCSE match for SSDI.

29. How many individuals did SSA prosecute last year for fraud on the DI and SSI programs?

We do not have the authority to prosecute persons for criminal violations; this authority rests with the Department of Justice and with State and local prosecutors. However, our OIG does refer criminal cases to these offices for prosecution. In FY 2009, our OIG's investigations led to 555 judicial actions (sentencings or pre-trial diversions) related to DI and SSI disability cases.

a. **How were these individuals identified?**

The chart below shows the source of information leading to the investigation, along with a break out of those receiving a sentence upon prosecution or a pre-trial diversion:

	JUDICIAL ACTIONS	
SOURCE OF INFORMATION	**SENTENCE**	**PRE-TRIAL DIVERSION**
SSA EMPLOYEES	279	53
STATE/LOCAL LAW ENFORCEMENT	69	2
FEDERAL LAW ENFORCEMENT	44	1
ANONYMOUS	32	3
PRIVATE CITIZENS	27	5
PUBLIC AGENCIES	19	
U.S. ATTORNEY	14	
OTHER	4	
NEWS MEDIA	2	
FOREIGN LAW ENFORCEMENT	1	
TOTAL	**491**	**64**

b. **What consequences did these individuals suffer?**

Consequences range from criminal prosecution to participation in a pre-trial diversion program. The outcomes of criminal prosecutions vary widely, and can include:

- a period of incarceration,
- supervised or unsupervised probation,
- court-ordered restitution, penalties, and fines, or
- all of the above.

The pre-trial diversion program is an alternative to prosecution that seeks to divert certain offenders from traditional criminal justice proceedings, generally prior to indictment, into a program of supervision and services administered by the U.S. Probation Service or any other appropriate community agency providing such services.

During FY 2009, in addition to the reported judicial actions, there were approximately:

- $824,729 in Judgments [1]
- $332,084 in Settlements[2]
- $17,341,474 in Restitution[3]
- $13,268,622 in Recoveries[4]
- $1,988,081 in Fines[5]

[1] **Judgment:** A judicially ordered payment resulting from a civil action, either through a Department of Justice civil proceeding or the Office of Counsel to the Inspector General's Civil Monetary Penalty Program, which can be characterized as either program or non-program related.
[2] **Settlement:** An agreement or resolution reached between the Government and the defendant as part of a civil action. The purpose of a settlement is to avoid trial and end the legal dispute between the Government and the defendant.
[3] **Restitution:** A court-ordered repayment resulting from Pre-Trial Diversions and convictions. Funds received in restitution can be categorized as program or non-program amounts.
[4] **Recovery:** A *non-court ordered repayment* of funds to which an individual was not entitled, or a seizure and return of funds to which an individual was not entitled. Funds received through recovery can be categorized as program or non-program related.
[5] **Fine:** A court-ordered penalty, including any special assessment fees, imposed upon conviction in a criminal case or judgment in a civil case and requiring that a specified sum of money be paid to the court.

30. Does SSA believe that a medical CDR mailer where a beneficiary is asked if they are "better, same, or worse" is an effective means of policing the disability programs? If yes, why? Please explain.

See the answer to Question 20c above.

31. At the hearing, Mr. Astrue stated that disability recipients reporting they have returned to work "[i]s complicated. So, particularly...some of these claimants have mental disabilities and some of them are not well educated." How can SSA rely on these same people to make a medical determination regarding their disability through a medical CDR mailer? Please explain.

a. **What qualifies a disabled beneficiary to make a medical determination that their health has improved?**

Beneficiaries do not make a medical determination about the status of their disabling conditions. As we discussed in our meeting with your staff on July 12, 2010, we use full medical CDRs to determine medical improvement under the statutorily defined Medical Improvement Review Standard. Please see the answer to Question 20c regarding the purpose of the mailers.

b. **Do the medical CDR mailers require that the beneficiary provide medical documentation describing their health when returning the mailer? Why or why not? If so, please list the documentation that SSA will accept in support of a beneficiary's claimed continued disability.**

The CDR mailer does not require beneficiaries to provide medical documentation because it is not the process we use to make a medical determination.

32. SSA appears to be performing more medical CDR through mailers. For example, in 2009 of the 1.1 million medical CDRs that SSA performed, 785,000 were mailers. SSA also states that, on average, a full medical CDR and consultative exam costs $1,000 and the mailer only costs $30 to process.

a. **Wouldn't full medical CDRs be more effective in removing healthy individuals from the disability rolls?**

Congress has not given us sufficient funds to perform all of the full medical CDRs that we would like, but we are moving in the right direction. The CDR models and mailer process allow us to efficiently use the full medical review process in the cases where beneficiaries are most likely to improve. The full medical CDR is our only process to remove beneficiaries from the disability rolls for medical improvement.

Prior to 1993, when we implemented the predictive models and mailer process, the program savings for CDRs were about $3 for every $1 spent to complete the CDRs. While it was a reasonable rate of return, we completed full medical CDRs for many disabled beneficiaries whose medical conditions were unlikely to improve. After we implemented the models and the mailers, we have increased our ROI to over $10 for every dollar spent completing CDRs.

We use large integrity samples to monitor the mailer deferral process. The samples, over 50,000 cases each year, incorporate outcomes for full medical reviews conducted on cases that our predictive models identified as CDR mailers.

CDR mailers are deferrals of a medical review (i.e., no medical review is necessary at this time), upon which we take no administrative action.

b. **According to SSA, the average monthly DI benefit payment to a disabled worker is $1,064. Would the lifetime benefit savings associated with removing a healthy individual from the rolls outweigh the $1,000 cost associated with a full medical CDR? Please explain.**

Yes. We receive about a 10 to 1 return for the taxpayers for every full medical CDR we perform.

c. **The CDR mailer essentially asks a person to self-report medical improvement. SSA has acknowledged that individuals on disability rarely self-report medical improvement or a return to work. Why is SSA increasingly reliant on self-reporting when SSA knows that it is ineffective?**

We are not screening more beneficiaries from full medical CDRs via the CDR mailer process than we have in the past. Please see the answers to Questions 20c, 31, and 32a above for more detail. As we say above, it is not correct to say that beneficiaries rarely self-report, and we do not rely solely on self-reporting.

d. **SSA states that 80 to 85 percent of individuals truthfully complete and return these mailers. Please provide the study results and any other data supporting this conclusion.**

We reported at our July 12, 2010 meeting with your staff that approximately 80 percent to 85 percent of beneficiaries who receive a mailer respond to the first mailer request. CDR mailer studies indicate that beneficiaries who had medically improved tended not to respond rather than to provide false information. We send a second request and, if the beneficiary does not respond, we designate the case for a full medical CDR.

Although our large model integrity samples indicate that our mailer process is performing as expected, we have no way of directly measuring what percent of responses are truthful, and we did not say that we did.

33. SSA has the authority to charge interest and impose penalties on individuals that receive overpayments.

a. **Why did SSA choose not to charge interest or impose penalties in its agreements with the individuals listed in this report?**

Our strategy for improving debt collection has been to focus on the techniques that provide direct collections that we can easily integrate into our existing systems. In keeping with this strategy, we have implemented several of the debt collection tools that the Debt Collection Improvement Act authorized us to use. We began with the implementation of TRO in 1992. Since then, we have expanded our debt collection

program by implementing Credit Bureau Reporting, Administrative Offset, Administrative Wage Garnishment, and FSO.

While we do not currently charge interest or impose penalties on overpayments, we are exploring the feasibility of implementing this action and, if feasible, how best to do so.

b. **Even when the individuals committed fraud?**

If we implement our process to charge interest or impose penalties, we will adhere to those guidelines on all debts, including those arising from fraud.

c. **When does the SSA deem it appropriate to charge interest or impose penalties?**

The law states that interest accrues on debts from the date on which we mail the original overpayment notice; it authorizes us to waive that interest if we fully recover the debt within 30 days; it allows us to assess a penalty of not more than 6 percent a year for failure to pay a part of a debt more than 90 days past due. If we implement our process to charge interest or impose penalties, we will adhere to those guidelines on all debts.

34. Does SSA admit individuals back on the rolls that were previously determined to be defrauding SSA?

Current law does not allow us to refuse to pay benefits to an otherwise eligible person due to a prior conviction of defrauding Social Security programs. However, current law does prohibit a person who has been convicted of defrauding the Social Security program from becoming a representative payee for a Social Security beneficiary.

If we determine that a person withheld information or gave false information, we have authority to withhold Social Security or SSI benefits for 6 months in the case of the first offense, 12 months for a second offense, and 24 months for any subsequent offenses. In addition, we have the authority to impose civil monetary penalties and assessments in lieu of damages against persons who make false statements or representations for use in determining the right to, or amount of, Social Security or SSI benefits.

35. The GAO Report states that SSA officials stated that all working beneficiaries covered by Extended Period of Eligibility (EPE) were entitled to receive a $250 stimulus check. However, the Recovery Act states that these stimulus payments were to be provided to individual who are entitled to DI benefit payments or are eligible for SSI cash benefits. By definition, a beneficiary in EPE is not entitled or eligible for cash benefits because they are working above Substantial Gainful Activity (SGA).

a. **Please explain why SSA paid roughly $10.5 million in stimulus payments to approximately 42,000 individuals who were in the Extended Period of Eligibility (EPE) and no longer entitled or eligible for benefit payments?**

Under the Social Security Act, beneficiaries remain "entitled" to benefits until they complete their EPE. Accordingly, any beneficiary who was in an EPE during the 3-month eligibility window for Economic Recovery Payments (ERP) was "entitled to a benefit payment" for purposes of the ARRA.

b. **Did SSA attempt to separate beneficiaries currently receiving disability payments from those in Extended Period of Eligibility (EPE)?**

No, the ARRA language did not specifically address persons in an EPE, but as noted above, such persons are "entitled to a benefit payment" for purposes of ARRA.

c. **In your responsive comments to the GAO Report, SSA states that it consulted the Office of General Counsel with regard to distributing stimulus checks. What did they advise?**

We sought the advice of the Office of the General Counsel consistently throughout the development and implementation of policy and procedures for making ERPs, including but not limited to the process of selecting particular classes of persons to certify, or not certify, for ERP eligibility. In addition, personnel from the Office of the General Counsel participated in meetings involving the identification and selection of ERP-eligible individuals.

d. **What process did SSA employ to distribute the stimulus checks?**

Pursuant to section 2201(a)(1)(A) of the ARRA, the Department of Treasury was responsible for disbursing the payments. Section 2201(b) required us (as well as the Railroad Retirement Board and the Department of Veterans Affairs) to "certify the individuals entitled to receive payment under this section and provide the Secretary of the Treasury with the information needed to disburse such payments."

36. For the states listed below, please provide 2009 data by county for: (1) the percentage by diagnostic group of the individuals in DI, SSI, and both of the disability programs; and (2) the number of individuals by diagnostic group in DI, SSI, and both of the disability programs. Please use the same diagnostic groups found in SSA's Annual Statistical Report on the Social Security Disability Insurance Program, 2009, Table 68.

a. **Alabama;**
b. **Kentucky;**
c. **Mississippi;**
d. **Virginia; and**
e. **West Virginia**

Enclosed are five Excel workbooks. There is one workbook for each State, with each workbook containing individual worksheets for each county (and, in the case of Virginia, each independent city) in that State. The tables include counts and percentages of beneficiaries aged 18-64 receiving Social Security disability benefits only, SSI disability payments only, and those receiving both Social Security and SSI disability benefits. The Social Security categories are further broken down into those receiving disability benefits as workers, widow(er)s, and adult children.

Because the congressional exception found in (b)(9) of the Privacy Act applies, we have the authority to release this information, which consists of data related to a small number of recipients by county. To protect the privacy of our beneficiaries, we respectfully request that this information not be released to the public. Please suppress any data with fewer than 10 beneficiaries in total because such a small number in a county could, if combined with other publically available information, potentially lead to a beneficiary being identified.

37. Please explain SSA's use of "predictive modeling" in the disability programs and provide any models currently used in those programs.

We use predictive modeling in the disability programs to better serve the public and to perform our program integrity work more efficiently.

Predictive Models to Improve Service to Claimants with Severe Health Conditions

We have developed predictive models designed to improve service to persons with severe disabilities who clearly meet our disability standards. These predictive models include the Quick Disability Determination (QDD) process, the Compassionate Allowance (CAL) process, the Presumptive Disability (PD) process, and the terminal illness (TERI) process.

The goal of the QDD process is to make faster disability decisions for claimants:

- who have medical conditions that reflect a high probability of meeting our disability standards; and
- whose medical evidence is easily and quickly verifiable.

We use an automated screening tool that captures data from the electronic disability application to identify potential cases for the QDD process. For cases identified through QDD, we attach an indicator to the record alerting the adjudicator that the case needs to be fast-tracked.

The CAL process identifies claimants with diseases and other medical conditions that invariably qualify under the Listing of Impairments based on minimal objective medical information. The PD process allows certain initial SSI disability claimants to receive payments in advance of formal medical determination by the DDS if they meet specified medical criteria. DDSs and field offices authorized to make PD determinations for special impairment categories can make PD determinations in any case with high probability of allowance. Claimants may receive up to 6 months of payments based on PD prior to a formal DDS determination.

The TERI process expedites claims that have an indication of terminal illness. Field office or DDS staff may identify TERI cases. CAL, QDD, and PD cases involve high probability of allowance, but do not necessarily meet the terminal illness criteria.

Predictive Models to Perform our Program Integrity Workload

We use predictive modeling in a number of business processes to prioritize workloads to help ensure we use the most productive and cost effective reviews. Our current predictive models include:

- SSI Redetermination Scoring Model: Prioritizes cases for SSI redetermination based on the expected value of detected overpayments found through a redetermination;
- Medical CDR Scoring Model: Determines the most cost-effective type of CDR (full medical review or CDR mailer) and prioritizes medical CDRs based on the likelihood of medical improvement;
- Medical Diary Scoring Model: Determines the optimal time to conduct medical CDRs based on the likely timing of medical improvement;
- Pre-Effectuation Review Model: Determines the most cost-effective 50 percent of mandated PER reviews based on the expected likelihood of an erroneous DDS disability allowance;
- SSR/IRS and OCSE Wage Models: Identifies those cases likelihood to yield the highest ROI through Limited Issue SSI Redeterminations; and
- Medicare Part D Subsidy Model: Identifies those cases most likely to have an incorrect Medicare Part D subsidy. CMS and we use this model to initiate Part D Subsidy redeterminations.

Enclosures

Cost Benefit Analysis for a Pilot Computer Match between the Office of Child Support Enforcement (OCSE) Quarterly Wage File and the Disability Insurance (DI) Master Beneficiary Record (MBR)

Match Objective

To determine the cost-effectiveness of a batch matching operation between the Disability Insurance MBR and the OCSE Quarterly Wage file.

Background

SSA has been using quarterly wage data from the OCSE National Directory of New Hires data base in a batch matching operation with the Supplemental Security Record (SSR) for several years. However, the Agency has not tested the use of OCSE wage data for Title II DI program integrity. A match between the OCSE quarterly wage file and the SSA MBR would alert SSA to a beneficiary's work activity many months (over nine months in some cases) before the annual Continuing Disability Review Enforcement Operation (CDREO) alerts are generated. This could result in more timely investigations of work activity, Substantial Gainful Activity (SGA) disability cessation determinations and reduction of overpayments. A pilot match could help SSA determine if an ongoing automated match between the OCSE quarterly wage file and the SSA MBR should be implemented.

Sample Selection

OQP obtained a random sample of 43,935 of the approximately 8.9 million Title II beneficiaries who were entitled to a disability insurance benefit (DIB) in calendar year 2007. This sample was matched to the OCSE quarterly wage file using the following matching criteria:

- The earnings for at least 1 quarter in 2007 were over the SGA level ($2,700 or $4,500 if the beneficiary was blind).
- The date of entitlement to disability (DOED) was prior to 01/01/2007.

This resulted in the identification of 3,052 accounts. A random sample of 680 cases was selected from this sample.

Review Methodology

OQP staff set up an hypothetical alert date of 6 months after the end of each quarter for each of the study sample cases. This is the same timeframe used to generate alerts from the OSCE quarterly wage matching operation with the SSR. The first quarter alerts would have been generated on October 1, 2007. The alerts for the later quarters would have been generated on January 1, 2008, April 1, 2008, and July 1, 2008.

From the 680 case study sample, OQP staff screened out cases that belonged to the following categories:

- A DIB cessation input prior to the hypothetical alert date,
- Under field office investigation at the time of the hypothetical alert,
- Full retirement age reached before hypothetical alert,

- Died before the hypothetical alert date, and
- Awarded a closed period of DIB after date of the hypothetical alert.

OQP then examined the remaining 326 alerts from the study sample. Information on the MBR, DCF, Payment History Update System (PHUS), Summary Earnings Query (SEQY) and Detail Earnings Query (DEQY) and eWork development was used to perform the study. The 326 alerts were then separated into three categories:

- Cases that had a CDREO alert generated for 2007,
- Cases that did not have a 2007 CDREO but had 2007 MEF earnings, and
- Cases that did not have a 2007 CDREO and did not have 2007 MEF earnings.

Cases with a CDREO Alert for 2007

There were 59 cases with a CDREO alert for 2007 wages. For these cases, the decision was examined and the amounts of the actual overpayment were recorded. Any overpayment that occurred before the potential alert date was counted as an overpayment that would have been discovered earlier by the alert generated from the OCSE/MBR match. Any overpayment amount that occurred after the hypothetical alert date was counted as an overpayment that would have been prevented.

The 59 sample cases project to about 54,000 beneficiaries annually. About 36 percent of the beneficiaries had overpayments that occurred before the hypothetical alert date. The average retroactive overpayment amount was $1,817 for these 54,000 beneficiaries. This projects to a total of $98 million in retroactive overpayments that would be detected. Assuming that 85 percent of these retroactive overpayments are recovered, retroactive overpayment benefits would be about $83 million.

In addition to retroactive overpayments, about 39 percent of the beneficiaries had overpayments that occurred after the hypothetical OCSE alert date. The OCSE alert would have prevented these overpayments from occurring. The average overpayment prevention amount was about $2,156, which projects to about $116 million in overpayment preventions for these 54,000 beneficiaries.

The alerts that result from the current CDREO process are worked by the PSCs, ODO, or the field offices. Based on the 2007 distribution of the CDREO among the three components, we estimate that the 54,000 OCSE alerts would be distributed as follows:

PSCs	25,000
ODO	27,000
Field Offices	1,700

Using the unit times, salaries, and overhead costs for the three components, we estimate that OCSE alert development costs would be about $6.2 million. In addition to development costs, the approximately 19,000 cases with retroactive overpayments would incur overpayment recovery costs of about $145 per case, or about $2.8 million. Adding in Systems costs and OCSE reimbursement, the total cost for the 54,000 alerts would be about $9 million. This compares to retroactive and recurring benefits of $199 million, for a benefit cost ratio of 22 to 1

for the OCSE alerts that were also CDREO alerts. See Appendix 1 for more detailed information about overall benefits and costs for this category of alerts.

Most of the savings from the 54,000 OCSE alerts would be recovered by the current CDREO alert process. For example, the $83 million in recovered retroactive overpayments would also be recovered when the CDREO alerts are worked at a later date. If the overpayment preventions of $116 million were not worked until after they became retroactive overpayments at the time of the CDREO alert, 85 percent would be recovered. Therefore, the only additional savings from the 54,000 alerts in this category would be 15 percent of $116 million, or about $17 million. Appendix 2 has more details about the benefit computations for the additional OCSE alerts.

Cases with No CDREO Alert and MEF Earnings for 2007

There were 77 cases in which the beneficiary had MEF earnings posted for 2007 but no CDREO alert was produced. These 77 cases project to about 70,000 beneficiaries. Possible overpayment amounts were estimated on these cases where a work CDR had not been completed. All posted earnings from 2002 through 2008 were considered. The actual CDR determinations were used for any of those earnings that had been previously investigated by SSA in determining any trial work period (TWP) months and SGA decisions. TWP months and SGA determinations were estimated for periods of work that had not been developed. The estimated TWP and SGA suspension months were determined by dividing the yearly earnings by the TWP month or SGA amounts for that year. The estimates given in these cases show the maximum possible overpayments. It was not possible to obtain actual amounts on these cases without developing them by contacting beneficiaries and employers.

The maximum possible recovered retroactive overpayment amount for these cases was about $1.5 million. The maximum overpayment prevention amount was about $4.4 million. Therefore, the maximum total overpayment benefit would be about $5.9 million. Since none of these cases would be alerted under the current CDREO process, this benefit amount would all be in addition to current benefits.

The cost to work the additional 70,000 alerts in this category would be about $8.9 million. Therefore, the maximum benefit cost ratio for these cases would only be about .7 to 1, or 70 cents in benefits for every dollar spent.

Cases with No CDREO Alert and No MEF Earnings for 2007

There were 190 sample cases that would have been alerted by the OCSE process but were not alerted in the CDREO process and had no MEF earnings for 2007. These sample cases project to about 173,000 beneficiaries. We believe the majority of these cases involve incorrect SSNs on the OCSE data base.

None of these cases would produce overpayments. Since none of these cases would involve SGA determinations, there would be no field office costs. The PSC/ODO unit times should be less than the other two categories of OCSE alerts. We believe a unit time of 30 minutes, or about half that of the unit times for the other two categories, would be reasonable for these alerts. This assumption produces a cost of about $8.3 million to work this category of OCSE alert.

Overall Benefit Cost Ratio

At the time that a DIB/ OCSE quarterly wage alert could be produced, it would not be possible to determine which of the three categories an alert fell into. This is because the MEF earnings would not yet be posted. Therefore, all three categories of alerts would need to be worked if a quarterly DIB/OCSE wage match were implemented.

About $205 million in retroactive overpayment recoveries and recurring payment preventions would accrue from working all 297,000 alerts that would result from this match. Total costs to work all of these alerts would be about $26 million. Thus, the overall benefit cost ratio would be 7.8 to 1.

Benefits and Costs in Addition to CDREO Alert Process

The overall benefit cost ratio can be misleading because many of the OCSE benefits would be captured by the current CDREO alert process. For example, the only OCSE benefits that would not be captured from the CDREO alerted cases would be 15 percent of the recurring overpayment preventions, or about $17 million. The savings of $6 million from those cases with MEF earnings, but no CDREO alert, would also be savings that are not captured under the current CDREO process. Therefore, the additional savings attributable to the DIB/OCSE alerts would be about $23 million.

Additional costs would accrue from all the cases that are not CDREO alerted. This would be an additional 243,000 alerts annually. These additional alerts would cost about $17 million. Therefore, the benefit cost ratio for the additional alerts generated by the OCSE matching operation would be about 1.4 to 1.

Sampling Variability for Additional Benefits and Costs

The sample size for this pilot match evaluation was only 326 cases. Large sampling error can be associated with small samples. This could mean that the benefit cost ratio for this match, if implemented, might be much different than the benefit cost estimate from our sample.

We estimated the sampling error on the benefit cost ratio of 1.4 to 1 for the additional benefits and costs. We found that a 95 percent confidence interval around the 1.4 to 1 estimate would range from .2 to 1 to 2.5 to 1. In other words, there is a 95 percent chance that the actual benefit cost ratio for this match, if implemented, would be between .2 to 1 and 2.5 to 1. There is only a 2.5 percent chance that the actual ratio would be greater than 2.5 to 1 and a 2.5 percent chance that the actual ratio would be less than .2 to 1.

Conclusions

- A match between the MBR disabled beneficiaries and OCSE's quarterly wage data would yield an estimated $23 million in overpayment preventions and recoveries on an annual basis that would not be captured by the current work CDR Enforcement Operation.
- The estimated cost to work the additional 243,000 alerts resulting from a match with OCSE quarterly wage data would cost about $17 million.
- The estimated return on investment would be about $1.40 for every dollar spent on working the additional alerts.

Recommendation

OQP does not recommend implementation of a match between OCSE's quarterly wage files and the DI MBR since a large number of additional alerts would be generated and the expected return on investment would be low.

Appendix 1

Overall Benefits and Costs

	CDREO Alert	No CDREO Alert		Total
		MEF Earnings	No MEF Earnings	
Benefits				
Sample Cases	59	77	190	326
Projected Beneficiaries	53,740	70,135	173,061	296,936
Percentage of Beneficiaries with Retroactive Overpayments	35.6%	7.8%	0.0%	8.3%
Beneficiaries With Retroactive Overpayments	19,128	5,465	0	24,593
Average Retroactive Overpayment Amount	$1,817	$332	$0	$2,150
Retroactive Overpayment Amount	$97,664,886	$1,815172	$0	$99,480,058
Recovered Retroactive Amount (85%)	$83,015,153	$1,542,897	$0	$84,558,049
Percentage of Beneficiaries With Overpayment Preventions	39.0%	7.8%	0.0%	8.9%
Beneficiaries With Overpayment Preventions	20,949	5,465	0	26,415
Average Overpayment Prevention Amount	$2,156	$800	$0	$2,956
Total Overpayment Prevention Amount	$115,873,065	$4,372,995	$0	$120,246,060
Total Overpayment Benefits	**$198,888,218**	**$5,915,892**	**$0**	**$204,804,109**

Overall Benefits and Costs

	CDREO Alert	No CDREO Alert		Total
		MEF Earnings	No MEF Earnings	
Costs				
PSC Processed Alerts[1]	24,599	32,104	79,218	135,922
PSC Unit Time[2]	63	63	30	
PSC Overhead[3]	2.31	2.31	2.31	
PSC Workyears	53.6	87.4	107.6	
PSC Salary[4]	$84,566	$84,566	$84,566	
PSC Development Cost	$2,406,545	$3,165,895	$3,719,975	$9,292,415
ODO Processed Alerts[1]	27,453	35,830	88,411	151,694
ODO Unit Time[2]	68	68	30	
ODO Overhead[3]	2.53	2.53	2.53	
ODO Workyears	71.2	115.3	131.5	
ODO Salary[4]	$84,566	$84,566	$84,566	
ODO Development Cost	$3,200,384	$4,176,895	$4,547,040	$11,924,319
FO Processed Alerts[1]	1,688	2,204	0	3,891
FO Unit Time[2]	243	243		
FO Overhead[3]	1.96	1.96		
FO Workyears	12.1	19.6		
FO Salary[4]	$84,566	$84,566		
FO Development Cost	$543,776	$709,986		$1,253,762
Systems Cost	$5,029	$6,564	$16,196	$27,789
OCSE Reimbursement	$13,532	$17,661	$43,578	$74,771
OP Development/Recovery Cost	$2,781,563	$794,732	$0	3,576,295
Total Costs	**$8,950,829**	**$8,871,733**	**$8,326,790**	**$26,149,351**
B/C Ratio	**22.2**	**0.7**	**0.0**	**7.8**

[1] Proportion of alerts processed by the three components furnished by OS

[2] Unit times provided by OPSOS

[3] Overhead factors provided by OB

[4] Salary based on GS11/9 from FY 2008 General Schedule plus cumulative locality pay of 15.55 and 20 percent benefits

Appendix 2

Benefits and Costs in Addition to CDREO

	CDREO Alert	No CDREO Alert		Total
		MEF Earnings	No MEF Earnings	
Projected Additional OCSE Alerts[5]	0	70,135	173,061	243,196
Total Overpayment Benefits[6]	**$17,380,960**	**$5,915,892**	**0**	**$23,296,851**
PSC/ODIO/FO Development Cost	$0	$8,052,776	$8,267,015	$16,319,791
Systems Cost	$0	$6,564	$16,196	$22,760
OCSE Reimbursement	$0	$17,661	$43,578	$61,239
OP Development/Recovery Cost	$0	$794,732	$0	$794,732
Total Costs	**$0**	**$8,871,733**	**$8,326,790**	**$17,198,522**
B/C Ratio		**0.7**	**0.0**	**1.4**

[5] Additional quarterly OCSE alerts for CDREO alerted cases plus OCSE alerts with no CDREO alert

[6] 15 percent of preventions from CDREO alerted cases plus all benefits from cases with no CDREO alert

TABLE WITHHELD
EXEMPTION 9

SUPPLEMENTAL QUESTIONS FOR THE RECORD FROM SENATOR CLAIRE McCASKILL

1. **It was evident from the testimony presented during the hearing that there is disagreement between SSA and GAO regarding the extent of fraud and improper payments. It would appear that some of the disagreements are simply regarding methods and detailed definitions. Stepping back from details, one of the general take-aways of the GAO report was that SSA does not seem to be availing itself of some relatively "low-hanging fruit" in terms of additional data sources. These data sources vary in value, complexity and how difficult they are to obtain. Would you agree that additional data sources are available that you have not been using and that these sources could be valuable in finding improper payments and fraud?**

   We agree that there are data sources that we have not been using and that these sources could be valuable in finding improper payments. As your question implies, we must evaluate the data sources to determine whether the value of the information we would get from them is worth the cost of obtaining them and configuring the information to our systems. We are looking into the value of a match to Federal payroll data. In addition, we are conducting pilot projects that make use of other data sources to identify improper payments and fraud.

2. **In generating models that would be capable of identifying cases that should not be receiving benefits there are two opportunities to get it right; the first and best opportunity is at the approval process, while the second is via review after a beneficiary has begun receiving benefits. While you mentioned that you have to accept any licensed doctor's approval, there are certainly some doctors that might raise suspicions based on the number of disability claims they are part of, how many of the cases they are involved in turn out later to be fraudulent, etc. Could you provide an outline of how you use computer algorithms on the front end to help disability offices and administrative law judges (ALJs) make their determinations and/or determine which cases merit extra scrutiny as well as how they work? If there are similar algorithms on the back end after benefits are being distributed that are used to determine which cases to re-examine how do these programs work and are the two modeling results (pre and post-award) connected? Any modeling is improved by the amount of information that is provided, so it is important that we don't have multiple modeling programs operating in isolation of each other. Are you integrating all front-end and back-end modeling so that they inform each other?**

   We do integrate our front-end and back-end modeling. On the front-end, we use a number of variables (alleged impairment, age, medical sources, etc.) to help predict which cases are most likely to be quick allowances.

When performing medical continuing disability review (CDR) models, we link the front-end and back-end disability processes by using data that reflect the decisions resulting from both processes. In the medical CDR model, for example, we employ a number of variables to reflect the level of entitlement and stage of the five-step sequential evaluation process used in the initial disability determination process. Using these data in conjunction with post-entitlement demographic and medical-related information allows us to predict likely medical improvement to efficiently prioritize full medical CDRs. Much of the same type of information (such as primary and secondary impairment) used in the medical CDR models is used in the front-end models; however, the front-end models typically rely on the claimant's alleged impairment and physical/mental limitations. In contrast, the back-end medical CDR review models rely on the primary and secondary impairment, in conjunction with other medical information that we collect at the time of the initial disability determination and/or the last medical CDR.

In the past, when we have sufficient data, we have tested additional variables used in the front-end of the disability process (most recently, presumptive disability indicators) but have not found that these indicators improve the overall performance of the medical CDR model. As part of our ongoing evaluation and research, we will continue to test our front-end models to determine if additional data can improve the performance of our back-end models.

3. **Many agencies like the Centers for Medicare and Medicaid Services (CMS) use third-party recovery contractors to perform automated reviews and subsequent recovery of improper payments. What is your view on the use of internal SSA resources versus external contractors to better locate and recover improper payments?**

While we currently have a robust system of internal controls for our administrative payments, we will consider using a contractor to perform recovery auditing of our administrative payments. We are somewhat skeptical about taking that route based on past experience. We used the services of a professional recovery-auditing firm on a contingency fee basis to review our administrative payments, and the firm determined that it was fiscally disadvantageous for them to continue the contract based on the minimal number of improper payments it found.

After we re-evaluate the options for recovery auditing of our administrative payments, we will report to the Office of Management and Budget (OMB) on the results of our review. In accordance with OMB guidance, we will initiate, consistent with our responsibilities under the Improper Payments Elimination and Recovery Act of 2010, recovery auditing if our analysis identifies a positive return on investment.

SOCIAL SECURITY

Office of Retirement and Disability Policy

November 23, 2010

The Honorable Max Baucus
Chairman, Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Thank you for your October 15, 2010 letter requesting additional information to complete the record for the hearing on long-term disability policies. This hearing was held on September 28, 2010. Enclosed you will find the answers to your questions, as well as the answers to Senator Grassley's and Senator Snowe's questions.

I hope this information is helpful. If we may be of further assistance to you or your staff, please do not hesitate to contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

/s/
David A. Rust
Deputy Commissioner
for Retirement and Disability Policy

Enclosure

Questions for the Record
For the September 28, 2010 Hearing
On Long-Term Disability Policies

Question from Chairman Baucus

1. **Mr. Rust, would it be helpful to the agency if it received evidence of an individual's alleged medical improvement or fraud from the private insurance companies?**

   Yes. While we cannot take action based solely on information from a private insurance company, we always appreciate any evidence from credible sources that can help us arrive at the correct disability determination, including medical evidence that would support discontinuing Social Security benefits or evidence of fraud.

Questions from Senator Grassley

1. **A number of comparisons could be made between Social Security and private disability insurance.**

   I would like to quickly run through a list of questions to clarify current Social Security policies. I believe a simple "yes" or "no" answer will suffice. But feel free to expand on your answers if necessary.

   Finally, for all of the questions you answered "yes" could you give us some idea of what the impact would be on Social Security if the answers had been "no" instead?

   (1) Is it true SSA has a medical release Form 827 that provides blanket authorization to obtain all medical records from any source, and failure to sign this form means the application will not be processed and benefits will be denied?

   It is true that our Form SSA-827 is a standard release form that a claimant can voluntarily sign to authorize release of information, such as medical records, to us. We developed the SSA-827 to comply with Federal and State provisions (such as the Health Insurance Portability and Accountability Act) regarding the disclosure of medical, educational, and other information.

   It is not true, however, that we will not process the application of a claimant who does not sign the SSA-827. In some cases, the claimant or his or her representative will provide us copies of medical evidence, which may be sufficient to make a disability determination. In these cases, we do not need to collect further evidence from outside sources.

Signing the SSA-827 is voluntary. If a claimant fails to sign the SSA-827 or revokes his or her authorization before we receive the information needed to make a disability determination, we could have difficulty obtaining that information. If we were unable to obtain the needed information, we likely would deny the claim.

(2) Is it true SSA often requires applicants to submit forms or schedule consultative exams, and failure to cooperate or comply with these requirements can result in the denial of benefits?

Yes, failure to cooperate can, but does not necessarily, result in the denial of benefits.

There are several reasons why we may need to send a claimant for a consultative examination (CE). A claimant may not have a regular medical provider who can submit evidence (for example, the claimant may be homeless and not have a primary care provider). Sometimes a claimant identifies a primary care provider, but that primary care provider is unable to provide any medical records or does not respond to our request for medical records. Sometimes the evidence we receive is incomplete or contradictory, and we must resolve those issues before we can make a determination. We may also need information from claimants regarding how their impairments affect their functioning. If a claimant fails to attend the examination or provide the required information, we may be unable to make a determination with the information we have in the file.

Under our regulations, if a claimant applies for benefits and does not have a good reason for failing or refusing to take part in a CE, we may find that the claimant is not entitled to benefits. If a claimant is already receiving benefits and does not have a good reason for not participating in a CE, we may determine that his or her disability or blindness has stopped. During the first eight months of calendar year 2010, we denied approximately seven percent of the initial disability claims we received due to the claimant's failure to cooperate in developing evidence for the claim.

We advise claimants that if there is any reason why they cannot go to a scheduled examination, they should tell us as soon as possible. We will reschedule the examination if the claimant has a good reason for not attending the CE. We will consider the claimant's mental, educational, and language limitations when we determine if the claimant has a good reason for failing to attend a CE.

If the Answer Had Been "No" – Under certain circumstances, if a claimant fails to cooperate, we will adjudicate a claim based on the evidence we have available. For example, we may be able to get the information we need from other sources (family members, medical providers) that will allow us to make a determination without the claimant's cooperation. However, if we cannot obtain the information needed to assess the medical severity of the claimant's impairments, we will deny the claim based on our "failure to cooperate" policy. Without this policy, these claims would remain open indefinitely.

(3) Is it true SSA often makes disability determinations based solely on the record without ever examining the applicant directly?

Yes. We require evidence from acceptable medical sources to evaluate whether the claimant has a medically determinable impairment. Medical reports should include a medical history, clinical findings, laboratory findings, diagnosis, treatment prescribed and the prognosis, and a medical source statement indicating what the claimant can do despite his or her medical impairment. If the evidence we receive is sufficient, we can make a disability determination based on that evidence.

If the disability determination services (DDS) does not receive evidence that is adequate to determine whether the claimant is disabled, the DDS will contact the claimant, contact medical sources, or schedule a CE. Generally, DDSs do not request a CE until they have made every reasonable effort to obtain evidence from the claimant's own medical sources.

In some cases, our adjudicators meet with the claimant before they make a reconsideration determination. If the claimant is appealing an initial determination that he or she is no longer entitled to disability benefits, we will provide the claimant with the opportunity for a face-to-face "disability hearing" at the reconsideration step of the administrative review process. A disability hearing officer in the DDS conducts this hearing. This review is in addition to the hearing a claimant may have before an administrative law judge (ALJ).

If the Answer Had Been "No" – Examining each applicant would considerably increase claim processing times and would also cause a substantial rise in our administrative costs, including additional costs for CEs. As many claimants "meet" our medical listings due to the severity of their impairments, further examining these claimants would have no bearing on the outcome except to delay the disability determination and payment of benefits.

(4) Is it true SSA has established Cooperative Disability Investigation – or CDI Teams – that often conduct surveillance to investigate cases of alleged disability fraud?

Yes. The CDI program is a joint effort between Federal and State agencies to pool resources to prevent fraud in our disability programs and related Federal and State programs. In some instances, the investigators will conduct surveillance of disability applicants during their investigations. According to our Inspector General, since the CDI program began in 1998, it has accounted for approximately $1.5 billion in Social Security program savings and approximately $900 million in non-Social Security program savings. These savings are the result of CDI units opening over 29,000 cases and developing evidence to support over 23,000 actions, resulting in denial, suspension, or termination of disability benefits.

If the Answer Had Been "No" – Without the CDIs, we would be paying benefits to persons who are defrauding the Government.

(5) Is it true SSA requires blind individuals under age 55 to establish proof that they are unable to engage in substantial gainful activity? In other words, benefits are not awarded solely on the basis of blindness?

Yes. To receive Social Security Disability Insurance (SSDI) benefits, blind persons under age 55 must be unable to engage in substantial gainful activity (SGA). A blind person under age 55 who is engaging in SGA is not disabled under the Social Security Act.[1] We use a higher earnings standard for blind persons to determine whether work activity is SGA.[2]

If the Answer Had Been "No" – SSDI benefits would be paid to blind persons regardless of their ability to engage in SGA, which would increase program costs.

(6) Is it true SSA disability cases reviewed by the federal courts are often remanded back to the agency?

Yes. Federal courts remand nearly one-half of the cases where claimants challenge our disability decisions.

If the Answer Had Been "No" – If courts remanded fewer cases, resources at the hearings and Appeals Council levels would be freed up to deal with the backlog of initial hearings requests and requests for review.

(7) Is it true SSA disability cases reviewed by the federal courts are not subject to a jury trial or treble damages?

Yes. Under the Social Security Act, Federal district court review of our final decisions is limited to a review of the administrative record by the judge. The review is essentially an appellate review, and there is no trial by either a judge or a jury. Judges are to determine whether our decisions are supported by substantial evidence, which is a deferential standard of review. District court judges may affirm, reverse, or modify our decisions, with or without remanding for a rehearing. There is no provision for damages; however, a claimant may be awarded attorney fees under the Equal Access to Justice Act.

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[1] A blind person may be eligible for SSDI benefits even though he or she is still engaging in SGA only if he or she is 55 or older and is unable to use the skills or abilities like the ones he or she used in any SGA that he or she did regularly and for a substantial period of time.

[2] However, we do not use SGA to determine initial eligibility for Supplemental Security Income (SSI) benefits. A blind individual may be eligible for SSI benefits even if they are performing SGA, provided they meet all other eligibility requirements.

If the Answer Had Been "No" – Presumably, a review by jury trial would result in a de novo review of our decisions with additional evidence outside the administrative record being admissible. This type of system for court review would result in little, or possibly no, deference being given to the highly skilled agency adjudicators and would leave to lay juries the ultimate determination of benefits and damages. Obviously, such a system would turn the entire process on its head and likely would result in higher costs to the disability program.

2. **I would like to explore the different standards of judicial review. As I understand it, Social Security is subject to a substantial evidence test.**

   When there is conflicting evidence, the court must defer to Social Security as long as its decision was supported by the evidence.

   Could you elaborate on this in terms of how the court would view different types of evidence? For example, would it give different weight to a treating physician report, as compared to a consultative exam, or another physician who only reviewed the medical records without directly examining the applicant?

   Our regulations describe how to weigh opinion evidence from various medical sources. Under these rules, we determine the weight to give a medical source opinion by considering a number of factors. We generally give more weight to an opinion from a treating source. We may even give the treating source opinion controlling weight if we find that the opinion is well supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the record. If the treating source opinion is not given controlling weight, we evaluate that treating source opinion along with all of the medical opinion evidence we receive, using several factors set out in our regulations. We consider the nature and extent of any treatment relationship. We also generally give more weight to an opinion from a medical source who has examined the claimant than to an opinion from a non-examining source, and we may weigh the opinion of a specialist in the field more heavily than an opinion from one who is not a specialist. When we weigh opinion evidence, we consider the evidence the source provides to support his or her opinion, any explanation the source offers to support the opinion, and the extent to which the opinion is consistent with the record as a whole.

   When a court reviews one of our decisions, it considers two broad inquiries: whether we have applied the correct legal standards and whether our decision is supported by substantial evidence in the administrative record. The reviewing court does not re-weigh the evidence as it would if it were the finder of fact. However, in determining whether we applied the correct legal standards, the court will review issues such as whether the ALJ properly applied our rules on weighing medical opinion evidence. If the court were to conclude that the ALJ did not weigh the evidence in the manner required by our regulations or that the ALJ did not provide a sufficient rationale in his or her decision to enable the court to determine how the evidence was weighed, the court may remand the case to have that deficiency

corrected. This type of remand, due to a perceived failure to follow the correct legal standard, is separate from the substantial evidence inquiry. The substantial evidence inquiry considers only whether, after properly weighing the evidence in the case, the ALJ's decision is supported by "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Substantial evidence is more than a mere scintilla, but less than a preponderance of evidence.

Questions from Senator Snowe

1. **Mr. Rust, the 2010 Annual Report from the Social Security Trustees indicated a serious funding problem with the Disability Insurance program. In fact the report stated "However, the DI Trust Fund is projected to become exhausted in 2018, so some action will be needed in the next few years." By this it meant that the disability insurance fund would no longer be able to pay full benefits to claimants and that Congress would need to take legislative action in the next few years to provide additional revenue or that benefit payments would have to be reduced.**

   While this committee has, at best, a tenuous jurisdictional association with the private disability insurance market, the potentially devastating impending exhaustion of the DI Trust Fund is clearly an imperative for us.

   Also of modest jurisdiction to the Senate Finance Committee is the new disability/long-term care insurance system being set up under the Patient Protection and Affordable Care Act (PPACA). Under the Community Living Assistance Services and Support (CLASS) Program provisions of health reform, the disabled and those with chronic illnesses who are still able to work and to participate everyday in their communities, and therefore may not be eligible for SSDI benefits, would be provided income to help cover their everyday expenses. Whether it is the Actuary for the Center on Medicare and Medicaid or the Congressional Budget Office, projections for the CLASS Program are that it will generate deficits relatively quickly after it is implemented.

   Mr. Rust, thank you for providing us with the ability to compare and contrast the claims process between private disability insurance and the SSDI process. Since you are the Deputy Commissioner for Retirement and Disability Policy, can you tell me whether there has been any discussion about whether there would be coordination of claims or benefit policies between the SSDI program and the new CLASS Program? If so, please provide us with information on how claims and benefits would be coordinated.

   We are still analyzing the provisions of the Affordable Care Act, and to date there have been no discussions about coordination of claims or benefit policies between the SSDI program and the CLASS program. We understand that the Department of Health and Human Services (HHS) has the responsibility for implementing the

CLASS program, and we will be sure to coordinate with HHS on this issue, as necessary.

The CLASS Act requires that the Secretary of HHS must seek out three actuarial soundness analyses prior to the creation of the CLASS Independence Benefit Plan. Has the Social Security Administration been asked to provide one of the three analyses?

No. Our Chief Actuary has not been asked to provide this analysis.

Have there been any discussions with states' Protective and Advocacy Systems as to whether any state will use the SSDI state offices?

No. To date we have had no discussions with any Protection and Advocacy Systems about this issue.

Will anyone from the policy office or other divisions within the Social Security Disability Insurance Program be involved in the implementation of the CLASS Act program and how these expanded responsibilities affect the administrative funding needs of the DI program?

No. There are currently no plans for SSA to be involved in CLASS implementation.

The Affordable Care Act includes a provision that excludes benefits received under the CLASS Act from consideration when determining a person's eligibility for the means-tested SSI program. We are developing instructions reminding our employees of this provision. Based on our understanding of the CLASS Act, we estimate its effects on our funding needs for administering the SSDI, SSI, and Old Age and Survivors Insurance programs to be negligible.

United States Committee on Finance Hearing

Hearing To Consider the Nomination of Carolyn Colvin To Be the Deputy Commissioner of Social Security"

Carolyn Colvin's Responses to Submitted Questions

Questions for the Record—Senator Chuck Grassley

Ex 63

Ex 66

2. The specific duties of the Deputy Commission are not defined in statute. Instead, the law authorizes the Commissioner to delegate such responsibilities. Given your knowledge and experience within the agency, can you identify some duties

you would like the Commissioner to delegate? Regarding these duties, what goals or objectives would you hope to achieve?

If confirmed, I hope to work closely with Commissioner Astrue on priorities such as reducing the disability backlog and ensuring that the Agency continues to build on its improvements so that we can reach the goal of entirely eliminating the disability backlog within the next two years. I also believe that, if confirmed, my strengths as an effective and efficient administrator will be an asset in addressing a wide variety of challenges facing SSA.

If confirmed, I also anticipate that I will have lead responsibility for overseeing SSA's efforts to identify, prevent, reduce and recover improper payments. I agree with the President that thorough identification of improper payments promotes accountability of Federal spending. Effective program stewardship means that waste, fraud, and abuse will not be tolerated.

The Executive Order that the President issued last November requires agencies to designate an official accountable for meeting specified targets for reducing and recovering improper payments. The executive order requires the accountable official to be in a Senate-confirmed position. Commissioner Astrue is the only current official at SSA in a Senate-confirmed position and, as such, he is SSA's accountable official in addition to all of his other duties as Commissioner. He has indicated that if I am confirmed, he would like me to assume that role.

Maintaining the public trust in Social Security programs through vigorous stewardship and program integrity activities is a primary goal for SSA. I understand that the agency has developed targets for reducing and recovering improper payments as required by the Executive Order, and I anticipate that I will be deeply involved in leading agency efforts to ensure that SSA meets those targets.

3. **In light of the report from President's Fiscal Commission, there has been a renewed focus on the need for Social Security reform. Can you explain how you see your role within the agency with respect to any legislative effort to reform Social Security?**

Under a longstanding arrangement within both the current and previous Administration, the White House and Department of the Treasury have the leads in addressing issues relating to solvency. My understanding is that SSA will continue to provide cost estimates and technical assistance on specific legislative proposals relating to reform, but any policy decisions would come from the White House and Treasury.

Questions for the Record—Senator Michael B. Enzi

1. **Given the nation's fiscal situation, government agencies like the Social Security Administration (SSA) will need to continue to provide high-quality service with the same, or perhaps less, resources. Based on your previous experience with the SSA, what are a few of the ways in which the SSA can streamline its operations and still provide the high-quality services needed by social security beneficiaries around the country?**

   I understand that SSA is looking thoroughly at its operations in light of diminishing resources. I know that SSA employees pride themselves on providing excellent service to the American people and will strive to continue to do so, even under less than ideal circumstances. Technology can help. During my previous tenure at SSA, we worked to improve the 800 number services. I understand that those services have been expanded further, and that SSA now has a robust system to provide callers with quick and accurate information. Individuals are also able to file for benefits over the internet, and there has been a significant increase in retirement claims filed using this method, often called I-Claims. Being able to use the telephone and internet to conduct business with SSA not only is convenient for the public, it also eliminates the need for people to come into SSA field offices.

   Further, I understand that SSA continues to consider administrative and policy simplifications that would make the operations of social security programs more efficient.

   Having to do more with less is inevitable. However, we still have the responsibility to be effective stewards of the trust funds. Therefore, if confirmed, I can assure you that I will explore all options for improving ways to carry out SSA's important mission and to make sure that we spend taxpayer dollars as efficiently as possible.

2. **In its December 1st final report, the National Commission on Fiscal Responsibility and Reform recommended a gradual increase in early and full retirement ages, based on increases in life expectancy. After the Normal Retirement Age (NRA) reaches 67 in 2027 under current law, the proposal would index both the NRA and Early Eligibility Age (EEA) to increases in life expectancy, effectively increasing the NRA to 68 by about 2050 and 69 by about 2075, and the EEA to 63 and 64 in lock step. The Bipartisan Policy Center, in its November 17th report, recommended that beginning in 2023 the benefit formula be indexed for increases in life expectancy and require the SSA to ensure that early retirees understand that they are opting for a lower monthly benefit. According to the report, these changes would increase the incentive to work longer, while not changing either the age of full retirement or the early retirement age from those in current law. Please provide your thoughts on these recommendations, and what other considerations you believe should be taken into account in this context as part of the discussion on the solvency of social security.**

The changes you reference are among many options that need to be considered. In fact, all options to address the financing problem facing Social Security must be on the table for consideration. I look forward to the Administration and the Congress working together on this important issue.

I am not able to comment on specific proposals relating to Social Security solvency. Under a longstanding arrangement with both the current and previous Administrations, the White House and Department of the Treasury have the leads in addressing issues relating to solvency.

Although I will not be working on solvency policy if confirmed, I expect to have the leadership role in assuring program integrity and stewardship, and a significant role in helping the Commissioner with his priority of reducing the disability and hearing backlogs.

Questions for the Record—Senator Tom Carper

1. **Improper Payments--Two programs run by the Social Security Administration are on the list of federal programs that report high levels of improper payments. The SSA reported that the Old Age and Survivors and Disability Insurance programs had improper payments estimated at more than $3.1 billion dollars for 2010. The Supplemental Security Income Program had estimates reported of more than $4.8 billion. Of course, improper payments are overpayments or other payments made improperly by a federal agency. These improper payments have been the focus of Government Accountability Office audits and hearings by the Homeland Security and Government Affairs Committee.**

   Please see subsequent responses that address these facts.

2. **Do you feel that the improper payments estimates reported by SSA represent a serious problem that needs attention by the Social Security leadership?**

   Improper payments are always serious and I believe that it is a primary function of government to take every possible step to ensure that taxpayer dollars are spent properly. If confirmed, I will work with the Commissioner and other SSA officials to explore every possible avenue to prevent, reduce, and recover improper payments in both the Social Security and Supplemental Security Income programs.

3. **The SSA Performance and Accountability Report for FY2010 lists some steps that SSA plans to take in order to address improper payments, called "corrective actions." Beyond the corrective actions listed, are their additional solutions you feel that SSA should consider to address improper payments within SSA programs? For example, have you considered preparing proposals to Congress for statutory or other changes that would curb improper payments (not just budgetary changes)? Could SSA make more expanded or improved use of the**

Automated Earnings Reappraisal Operations (AERO) program data, the National Directory of New Hires, or other databases such as those for federal employment?

I believe it is always appropriate to examine new solutions to the improper payments problem. If confirmed, I will review the current corrective actions as well as explore other steps that might be taken to improve the payment process. I will certainly examine how the AERO data and the other databases you mention might be used, and what information we might be able to obtain from those sources. Should we find a need for legislative changes in order to implement improvements, we will certainly bring those proposals to the Congress.

4. **Social Security Administration Death Master File--The Death Master File, maintained by the Social Security Administration to track the deaths of citizens and residents of the United States, is a key database not only for the work of the SSA, but many other agencies. This database's level of accuracy is critical for ensuring that the federal government can determine the eligibility of beneficiaries and providers of services. By checking the Death Master file, an agency can ensure that an individual is alive, and therefore people's identities are less likely to be stolen or misused for fraudulent purposes. For example, the Death Master File is used to update the list of providers and beneficiaries under the Medicare and Medicaid programs.**

Please see response to questions below.

5. **Are there proposals that SSA could pursue to improve the accuracy and availability of the Death Master File data? Could SSA increase the frequency of updates to the Death Master File? Are there proposals that Congress should consider to improve the submission of information to the Death Master File by the States or other sources?**

   - It is my understanding that the Death Master File (DMF) is very accurate. The SSA Inspector General audited the accuracy of the DMF in 2008 and reported that it was 99.59% accurate. If I am confirmed as Deputy Commissioner, I will review with appropriate SSA officials any additional steps that might be taken to improve this rate.

   - I understand that SSA now updates the DMF every week. As you note, Federal and State benefit paying agencies use the DMF to prevent fraud. These agencies receive the information from SSA at no cost. For commercial users, such as banks and insurance companies, which use the DMF to prevent identity fraud, the DMF can be purchased from the National Institute of Standards and Technology (NIST). The DMF sold by NIST is provided by SSA and is updated weekly.

   - I know that SSA receives death information directly from family members and from funeral homes as well as from State vital statistics departments. I also know

that more than 30 State and local vital statistics departments are reporting this information electronically to SSA. If I have the opportunity to serve as Deputy Commissioner, I will review with SSA officials how the DMF obtains information from the States and other reporters and examine whether there may be ways to improve the speed and accuracy of the information obtained from these sources. I will also work to see if there are additional steps SSA might take to encourage the remaining States to participate in the sharing of death information electronically with SSA. My understanding is that the main barrier to full State participation is the limited available funding for HHS to provide grants for this purpose.

[**NOTE**: Although not part of the questions for the record submitted by Senator Carper, I agreed during the hearing to provide for the record a response to his question about the chained CPI.]

The National Commission on Fiscal Responsibility and Reform proposed using a chained formula to calculate future cost-of-living increases. Would you explain the difference between the chained CPI and the current formula?

The Consumer Price Index (CPI) is a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services. When a cost-of-living increase is payable, the Social Security Administration (SSA) adjusts beneficiaries' monthly benefits based on any increase in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W). The Department of Labor, Bureau of Labor Statistics (BLS)—not SSA-- calculates this index. BLS would be the best source for information on the chained CPI. However, here is my understanding of the issue.

In 2002, BLS started publishing a Chained Consumer Price Index for All Urban Consumers. The index, designated the C-CPI-U, supplements existing indexes already produced by the BLS: the CPI for All Urban Consumers (CPI-U) and the CPI-W. The CPI-U and C-CPI-U are indexes that measure price changes faced by urban consumers, while the CPI-W measures price changes faced by urban wage earners and clerical workers (a subset of the population measured by the CPI-U). The raw data used to measure the CPI-U and CPI-W are the same; population coverage is the only difference.

The feature that makes the C-CPI-U different from the other indexes is that it uses a different mathematical formula to adjust the CPI to reflect the effect of any substitution that consumers may make in response to changes in prices between CPI categories. For example, if the price of beef rises but the price of pork does not, consumers may choose to purchase less beef and more pork. The C-CPI-U better reflects the effect of this substitution. As mentioned above, BLS would be in the best position to explain precisely how the C-CPI-U formula differs from the CPI-W formula used to calculate the Social Security COLA

SSA's Office of the Chief Actuary has estimated that using the chained CPI for purposes of the Social Security COLA would result in approximately a 0.3 percentage point smaller COLA each year.

SOCIAL SECURITY

The Commissioner

May 15, 2014

The Honorable Sam Johnson
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your March 5, 2014 letter requesting additional information to complete the record for the January 16, 2014 hearing on the disability fraud scheme in New York. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or have your staff contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

Carolyn W. Colvin

Carolyn W. Colvin
Acting Commissioner

Enclosure

Questions for the Record
from the January 16, 2014 Hearing
on the Disability Fraud Scheme in New York

1. **Given that the President has signed into law the Consolidated Appropriations Act, 2014, (P.L. 113-76), which provides the full authorized amount of $1.2 billion for Continuing Disability Reviews (CDRs) will you reinstate the requirement that the Social Security Administration (SSA) review disability claims every three years beginning in fiscal year (FY) 2014, after waiving the requirement in FY 2012 and 2013?**

   No. While the money Congress provided for our program integrity activities in FY 2014 is a substantial investment—one without precedent in recent history—it is not enough to eliminate the backlog of CDRs and complete all of the cases coming due this fiscal year.

   To provide some context, we expect to complete about 510,000 full medical CDRs this fiscal year, which is nearly a 20 percent increase from the FY 2013 level, but still well short of the 1.3 million cases currently backlogged.

   With a multi-year commitment of adequate funding from the Congress, we believe we can eliminate the CDR backlog. Unfortunately, receiving nearly an average of a billion dollars less than what the President requested for our administrative budget over the past 3 years has resulted in the loss of nearly 11,000 employees. For this reason, FY 2014 is a transitional year in which we will rebuild our personnel capacity to complete increasingly higher levels of CDRs in future years to be able to ultimately eliminate the backlog. We anticipate having to defer cases until the year in which we are funded to become current with this workload.

2. **Given that the recently appropriated $1.2 billion are temporary funds, intended to eliminate the current backlog of CDRs and Supplemental Security Income redeterminations, please separately provide us with your specific plan for how these funds will be spent.**

   On March 4, 2014, we submitted to the Congress our FY 2014 Operating Plan (Plan), as required by section 516 of the Consolidated Appropriations Act, 2014 (Public Law 113-76). The Plan includes details on our program integrity spending plans, and it is publicly accessible on our website at http://www.ssa.gov/budget/FY14Files/2014OP.pdf.

3. **In 2011 the SSA had a medical CDR backlog of 1.4 million. In response to a question for the record you stated that with full funding for program integrity as authorized in the Budget Control Act (BCA) the SSA could catch up on Title II medical CDRs by 2016. For FY 2014 the SSA has now received the fully authorized amount. What is your plan now to complete and stay current on medical CDRs for Title II beneficiaries? Please give us detailed numbers of CDRs (mailers and medical reviews), planned hiring, costs of doing these reviews, and any updated ratios of program savings.**

   Based on current estimates, we project that we will be able to eliminate our current backlog of Title II medical CDRs by the end of FY 2015, assuming the Budget Control Act of 2011

level of funding for program integrity in FY 2015. Current estimates suggest that, in the event funding were made available for the agency to become up to date on Title II medical CDRs, staying current (for both Title II and Title XVI) would require us to complete about 800,000 full medical CDRs per year.

In FY 2014, we plan to complete a total of 900,000 mailers and 510,000 full medical CDRs on both Title II and Title XVI beneficiaries, at a cost of about $600 million. In FY 2015, with full funding of the President's Budget, we plan to complete a total of 1.1 million mailers and 888,000 full medical CDRs, at a cost of about $1 billion. We are hiring staff in the State Disability Determination Services (DDS) this year to help us ramp up our cost-effective CDR efforts. We anticipate hiring a total of approximately 2,600 DDS employees in FY 2014, of which about 1,400 hires will be above replacement level for FY 2014 losses. We estimate that our FY 2015 program integrity fund will yield on average $9 in net program savings over the next 10 years per dollar spent on medical CDRs, including Medicare and Medicaid program savings.

4. **When a facilitator or claimant representative is formally accused of committing fraud, what are the procedures for quickly identifying other cases involving these fraudulent actors? How does the agency determine how far back case review will occur?**

Section 205(u) of the Social Security Act (Act) requires the Commissioner to redetermine the entitlement of individuals if there is reason to believe that fraud or similar fault was involved in the individuals' applications. An exception may be made in cases in which a U.S. Attorney, or equivalent State prosecutor, with jurisdiction over the case certifies in writing that such action would jeopardize the criminal prosecution. When redetermining entitlement or making an initial determination of entitlement, the Commissioner must disregard the tainted evidence. If the Commissioner determines that there is insufficient evidence to support entitlement, the Commissioner may terminate entitlement and treat benefits paid on the basis of such insufficient evidence as overpayments. The Commissioner determines how far back the case review will occur based on reliable evidence of the scope and duration of the fraudulent activity. Data mining can help to uncover reliable evidence of the scope and duration of the fraudulent activity by identifying cases potentially related to the fraud for further investigation.

5. **When a person, facilitator, claimant, or other individual, is suspected of committing fraud, is there an alert system to identify other cases these suspects may be involved in for review?**

When there is suspicious activity related to a claim, our best and first lines of defense are DDS examiners, claims representatives, and other frontline employees. These employees are highly trained in the administration of the disability program rules and are dedicated to protecting the program from abuse. We train staff to be alert to indications of potential fraud, including contradictory statements, suspicious documents, and tips from members of the community. When such indicators are present, employees will attempt to verify information by requesting additional documentation, communicating with third parties, interviewing the sources of information, or any combination of these. Employees then refer cases of potential

8. What is the cost of placing a Social Security attorney in a U.S. Attorney's office to help prosecute fraud?

We estimate that it would cost us roughly $150,000 to place one of our attorneys in a U.S. Attorney's office as a fraud prosecutor. We currently have 12 attorneys serving as fraud prosecutors and plan to double that number.

fraud to our Office of the Inspector General (OIG). In FY 2013, our frontline employees made approximately 22,500 referrals of potential fraud to OIG, of which OIG opened about 5,300 cases. Of the approximately 5,300 cases opened, OIG referred over 100 to the U.S. Attorney's Office for criminal prosecution. In many States, Cooperative Disability Investigations (CDI) units (led by an OIG Special Agent) are available to investigate individual disability cases to identify applicants or beneficiaries who commit fraud and attorneys, doctors, translators, and other third parties who facilitate fraud.

We are able to support fraud investigations by using our electronic systems to identify cases potentially related to the suspected fraud, and we work with our Office of the General Counsel regarding specific action to take given the facts. We alert employees about representatives who have been suspended or disqualified, and we maintain a website of sanctioned representatives. We also publish instructions about specific situations through our administrative and emergency message process.

6. **What have been the results of the reviews by Ms. Disman's staff of other cases from Puerto Rico that involved the same doctor, claimant representative or facilitator arrested in the investigation?**

We are still in the process of conducting redeterminations under section 205(u) of the Act but do expect to complete the initial redetermination of those cases not decided by an administrative law judge soon. Due to the ongoing criminal investigation, we would be happy to provide you the results in a private briefing.

7. **What would the cost be to make Cooperative Disability Investigation units available in every State?**

There are currently 29 States without CDI units. Based on current estimates, the average one-time cost to open a new facility is approximately $300,000 per CDI unit, so it would cost nearly $9 million to fund the new infrastructure needed for 29 new units.

Based on actual experience, ongoing annual operating costs to staff and support CDI operations are approximately $800,000 per CDI unit – which includes both SSA- and OIG-funded costs. These ongoing operational costs include law enforcement contracts, vehicles, IT equipment, supplies, facilities, and SSA and OIG staff salaries. Therefore, if we were to add 29 additional CDI units, the ongoing annual cost alone would be approximately $24 million.

As mentioned in the anti-fraud report we submitted to the Subcommittee on February 14, 2014, we plan to expand the number of CDI units from 25 to 32 by the end of FY 2015. With sustained, adequate funding, we will be able to continue to increase the number of units in future years.

SOCIAL SECURITY

The Commissioner

June 6, 2014

The Honorable Sam Johnson
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your March 20, 2014 letter requesting additional information to complete the record for the February 26 hearing on preventing disability scams. Enclosed you will find the answers to your questions. I am providing responses on behalf of Deputy Commissioner William Zielinski and myself.

On March 27, we sent you the timeline for implementing our anti-fraud initiatives that you requested during the hearing.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

Carolyn W. Colvin

Carolyn W. Colvin
Acting Commissioner

Enclosure

Questions for the Record
For the February 26, 2014 Hearing
On Preventing Disability Scams

Questions for Acting Commissioner Carolyn W. Colvin

1. **What is the most important action your agency has taken to stop the fraud and abuses seen in Puerto Rico, New York, and West Virginia, from happening in other parts of the country?**

   As I stated during the January 16 and February 26, 2014 hearings, I take my responsibility seriously for detecting and preventing any potential fraud. Our employees share the same view and actively identify instances where they believe fraud may occur or has occurred. We have a robust anti-fraud training curriculum for our employees to equip them with the skills to identify and report fraud.

   I mentioned in the February 26 hearing that many efforts are underway to further enhance our fight against fraud. I want to highlight the recent renewal of our National Anti-Fraud Committee co-chaired by our Inspector General and our Deputy Commissioner for Budget, Finance, Quality, and Management. In fact, they held their first Committee meeting on March 24.

   The goal of the Committee is to lead and support our national and regional strategies to prevent and combat fraud, waste, and abuse. We identified a number of baseline initiatives to combat fraud, and the Committee will ensure these initiatives are implemented. For example, we will expand our Cooperative Disability Investigations (CDI) units from 25 to 32 by the end of fiscal year (FY) 2015 and add staff to existing units. As I mentioned at the hearing, a CDI unit identified the fraud cases in New York. According to our Inspector General, CDI units contributed to agency savings of more than $960 million over the last 3 fiscal years.

   On March 31, we established a centralized fraud prevention unit in New York City to identify potential fraud and detect fraud trends that can be applied to disability cases nationwide. This unit consists of experienced disability examiners who will collaborate with our systems personnel to help build data analytics to detect and prevent fraud at the earliest possible point in the disability decision-making process.

2. **Your agency estimates the re-reviews in Puerto Rico will cost up to $6 million. How much will the re-reviews in the New York case cost?**

   The grand jury in the New York County case remains active and the criminal investigation is ongoing. We cannot estimate the costs of the reviews until after those activities have concluded. We have begun to review a limited number of cases arising out of the active grand jury investigation and will continue to review additional cases as the investigation unfolds.

3. How are employee actions to detect fraud accounted for in the agency's work measurement system?

Our *Annual Performance Plan for Fiscal Year 2015, Revised Performance Plan for Fiscal Year 2014, and Annual Performance Report for Fiscal Year 2013* establishes agency-level priorities and includes goals and objectives focused on program integrity, reducing improper payments, and fraud prevention and detection. You may access it at www.socialsecurity.gov/performance/2015/FY2015-APP-APR.pdf. Our agency-level performance measures that specifically address fraud prevention are as follows:

- 2.2a – Implement a fraud and integrity unit to protect the public's data;
- 2.2b – Enhance our security features and business processes to prevent and detect fraud; and
- 5.3b - Explore the use of emerging technologies by establishing a testing lab to promote research and development of innovative technology solutions that provide more effective and flexible ways for the public to conduct business with us online and for our employees to complete their work.

As I have consistently said, our front-line employees are our best line of defense against fraud and abuse. All of our employees are responsible for detecting and reporting potential violations of the law, developing sufficient evidence to establish any violation, reporting violations, assisting our Office of the Inspector General (OIG) in developing violations, and providing other support as needed.

We capture employee actions to detect fraud in our Fraud Information Tracking System (FITS), which houses data on fraud referrals made by our field offices to OIG, and hotline referrals transferred to the field office for development. The chart below shows fraud referrals for the last 5 years.

Fiscal Year	Fraud Referrals
FY 2009	44,919
FY 2010	47,764
FY 2011	49,757
FY 2012	69,774
FY 2013	83,827

Our Office of Disability Adjudication and Review is working with our Office of Operations to be able to use FITS to more effectively track fraud-related referrals.

4. **Of employee bonuses awarded in fiscal year 2013, what percent were given to employees based on their efforts to detect or prevent fraud?**

   We reviewed employee awards for FY 2013. We awarded eight Senior Executive Service performance bonuses in FY 2013, all of which were related to performance and accomplishments directed at detecting or preventing fraud. Due to budgetary considerations, we did not make any monetary awards to line employees in FY 2013.

5. **Conspiracy schemes also affect Social Security number holders. The Congress recently passed a law ending the publication of the Death Master File that Social Security produces and sends to the Commerce Department that then sells it to subscribers. All access to current deaths is to end March 26, 2014 in order to prevent identity thieves from stealing Social Security numbers of the deceased and using them to file for a fraudulent tax refund. As Acting Commissioner, how are you working with the Commerce Department, the Office of Management and Budget and the Internal Revenue Service to insure the protection of personal information of the deceased?**

   We compile the Death Master File (DMF) to respond to Freedom of Information Act (FOIA) requests. The file serves no program purpose for us. In order to comply with the high volume of DMF-related FOIA requests, we contracted with the National Technical Information Service (NTIS), part of the Department of Commerce (DOC) that functions as a national clearinghouse for government data, to make the file available to the public. The Bipartisan Budget Act of 2013 exempted from FOIA death information about individuals who died in the last 3 calendar years and tasked the DOC with a number of new responsibilities with respect to the DMF.

   The law requires the DOC to create a new certification program under which only persons having a legitimate business purpose for the information may have access to the file containing information on deaths occurring in the last 3 calendar years. Therefore, the general public will have access only to a file containing deaths that occurred at least 3 calendar years prior to the request.

   Our role in implementing the new law is a supporting one. We have continued to supply DOC with the DMF, on a reimbursable basis, so that DOC can distribute the DMF to certified persons as required by the new law. In addition, we have been working with NTIS and the Office of Management and Budget to provide advice and feedback as described below. In December 2013, for example, NTIS reached out to us to ask for our thoughts on implementation of the new legislation. This contact triggered a series of interagency meetings. We discussed several issues with NTIS throughout the month of January 2014, including:

   - the NTIS' draft regulation;
   - the history and purpose of the DMF;
   - our plans for improving our death reporting process and the accuracy of the DMF; and;

- the technical, resource, and contractual issues related to creating two files—one for immediate release to certified persons through the new DOC program and one for the delayed release of older death information available under FOIA.

In February 2014, we and other stakeholder agencies, such as the Department of the Treasury, provided comments on NTIS' draft "Request for Information" soliciting public comment on the establishment and implementation of the certification program, and in early March, we provided comments to NTIS' on its proposed interim final rule. On March 26, 2014, NTIS published their interim final in the Federal Register, Volume 79, Issue 58.

Questions for Deputy Commissioner Bill Zielinski

1. **As the Chief Information Officer, part of your job is to bring an agency wide perspective to the table. Before new policies and programs are rolled out, please describe how decisions are made regarding the data collection needed to prevent fraud. Will this process change going forward and if so, how? Also, please discuss how you have mapped out holes in your current data and ways to get what you need.**

   We use a variety of continuous monitoring processes to determine agency information needs around fraud and program integrity. Examples of such processes include Quality Assurance processes, our Audit Trail System, audit findings and recommendations (e.g., Federal Information Security Management Act, OIG, and Government Accountability Office), public reports, and OIG investigations. These continuous monitoring processes provide a rich source of information regarding vulnerabilities or threats from fraud. We analyze these processes and the data they yield to identify the potential for fraud, abuse, and error within agency programs. Based on these analyses, we decide what data to collect, where changes can be made to existing systems or processes, and where automation can be applied to prevent fraud or error in the programs. While we have used many of these processes for many years, and they have proven to work extremely well, there is always a need to review and update our detection and prevention programs to keep pace with new threats and leverage new and emerging technologies. Our staff uses data from agency repositories to determine emerging data needs. Along with data collected by the agency for purposes of program administration, we also look for external data sources that can assist in the detection and prevention of error and fraud in our programs. Examples include Medicare/Medicaid Non-usage data, financial data, and earnings data.

2. **What specific role will your office have in the agency's planned use of data analytics, as described in the Acting Commissioner's plan, to prevent and detect disability fraud?**

   The Office of the Chief Information Officer is leading the effort to expand our use of data analytics to enhance our ability to detect possible fraud. My office will apply analytics tools that can determine common characteristics and meaningful patterns of fraud based on data from past allegations and known cases of fraud. We will apply these tools when reviewing business applications or existing data on beneficiaries for potential fraud or other suspicious behavior. With these predictive tools, we will increase our capability to identify suspicious patterns of activity in disability claims and prevent fraudulent applications from being

processed. During the remainder of FY 2014, we will test the value of these analytical tools in the disability process to determine their effectiveness in detecting and preventing possible fraud. If our tests determine that these tools will help us detect and prevent fraud, we plan to start implementing them as early as FY 2015.

3. **In your testimony, you highlight the work at the hearings level to employ data analytics tools. For instance, the hearings operation is able to determine when a particular Administrative Law Judge is paired with a particular claimant representative, if the approval rate is statistically different. What lessons have you learned from these initiatives? How will those lessons be applied to other stages of the disability process? How will you expand data analytics to improve the timeliness, accuracy, and consistency of decisions at all levels?**

Our Office of Disability Adjudication and Review has been increasingly successful in using data analytics as a part of a strategy to improve the disability adjudication process. This strategy includes capturing and analyzing data to find anomalies requiring further study, conducting focused reviews of anomalies, and then working with other Agency components to determine appropriate actions. These actions may include recommending policy changes, enhancing training and feedback to individual employees, and making referrals to our OIG.

These efforts have coincided with a significant drop in the percentage of "outlier" administrative law judges (ALJ), defined as those allowing greater than 85 percent or fewer than 20 percent of their cases. The percentage of outlier ALJs dropped from 20 percent in FY 2007 to 3.6 percent in FY 2013. In addition, as we improved training, feedback, and policies, we have seen a decline in the rate at which the Appeals Council grants review of ALJ decisions from 29 percent in FY 2007 to 19 percent in FY 2013. The Appeals Council has also been successful in using data analytics to increase the productivity of its employees and reduce the average age of cases pending review.

Acting Commissioner Colvin directed expansion of the hearings operation data analytics approach to other disability process areas to teach other components how to follow that data analytic model for making data driven decisions. Classes are underway for employees of the other components. The ultimate goal of this approach is to improve the accuracy, timeliness, and policy consistency of agency decisions.

The hearings operation model has taught us that we can use data analytics to discover patterns of activity and sequences of events that can be indicative of fraudulent actions. Members of my office have met with many different offices in the agency to discuss sequences of events that can help us identify fraud at different levels of the application process. The analytics tool we are developing will, in part, use the information we have gained from analyzing the events that occurred in the hearings operation to identify fraud and improve the accuracy of our disability decisions at all levels.

In addition to the hearings operations model that focuses on improvement of the disability adjudication process, the Acting Commissioner has also created a cross-component group that will target, identify and, where possible, prevent disability fraud using predictive data

analytics. She has also given the Chief Strategic Officer the lead to coordinate and improve data analytic efforts throughout the agency.

4. **How have you reached out to industry leaders and how do you plan to use their expertise when developing data analytics capabilities?**

Industry leaders are among the variety of information sources we leverage to evaluate emerging technologies. We have had many discussions, presentations, and demonstrations with industry leaders to refine our vision regarding data analytics capabilities within our agency. We use the information we get from these industry leaders to determine best-of-breed products and processes. We also reach out to other agencies to learn what products and vendors they have used, as well as to vendors for demonstrations of key capabilities of their products.

Over the last several months, we have met with industry leaders in data analytics to identify a tool that we can use in conjunction with our back-end Big Data environment to detect disability fraud. We have now identified a vendor we will work with to implement such a tool. By the end of FY 2014, we will determine if the tool could have identified the disability fraud events in New York, Puerto Rico, and West Virginia. Also by the end of FY 2014, we plan to be using this tool to identify the risk level of particular disability claims.

In addition, we are moving forward in developing a data analytics laboratory. In order to ensure we develop this laboratory using the standards and processes relied on in the data analytics industry, we have met with various industry leaders. We have and will continue to visit such laboratories, including the data analytics lab at the Centers for Medicare and Medicaid Services.

SOCIAL SECURITY

The Commissioner

June 18, 2013

The Honorable Jack Kingston
Chairman, Subcommittee on Labor,
Health and Human Services, Education and Related Agencies
Committee on Appropriations
House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your April 11, 2013 request for additional information to complete the record for the March 14, 2013 hearing on service delivery challenges. Enclosed you will find the answers to questions from members of your subcommittee.

I hope this information is helpful. If we may be of further assistance to you or your staff, please do not hesitate to contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

Carolyn W. Colvin

Carolyn W. Colvin
Acting Commissioner

Enclosure

Department of Labor, Health and Human Services and Education and Related Agencies

Social Security Administration Oversight Hearing
March 14, 2013

QUESTIONS FOR ACTING COMMISSIONER COLVIN TO BE SUBMITTED FOR THE PUBLIC HEARING RECORD

Chairman Kingston

INFORMATION TECHNOLOGY UPGRADES

SSA's current mode of serving the public is not functioning well. The strains on local offices have reached the point where they are seriously hampering SSA's ability to function. It is evident that both the public as well as the SSA workforce would benefit from a number of services being automated. Please address in detail the agency's plans to exploit technological advances to make service automation possible. Include a list of functions and services that you plan to automate as well as an estimate of the costs and period of time required to perform the necessary development, testing and deployment work.

We have made great strides in recent years to become a highly automated, mostly paperless agency; our enterprise systems are available to end-users, with good response times, over 99.9 percent of the time. Our Internet applications for the public and businesses are thoughtfully designed, highly rated (by the independent American Customer Satisfaction Index and our own surveys), and have allowed us to maintain high and improving service levels even with rising workloads. Just to name a few other recent information technology initiatives, we are piloting a new case processing system for State disability determination services ([DDS] i.e., the State agencies that process initial disability claims); building a national visitor intake system for our field offices; adding more advanced systems capabilities in our hearing offices; converting our master-files to DB2 databases; increasing the use of video for appeals and operational workloads; modernizing our earnings record software; building more agile data exchange programs; and building more online services for our "My Social Security" portal.

With workloads at an all-time high, we must continue to capitalize on new technologies to cut costs, operate more efficiently, and provide the services Americans deserve. We must continue to respond to the fiscal realities, which means that we cannot do business as we always have.

In answer to your question, I discuss below our vision for developing a long-term strategic plan. A crucial part of that plan includes plotting a course of information technology (IT) development that will allow us to continue to automate work, increase efficiency, and offer more online services. In our current IT planning process, we define and prioritize the IT initiatives to accomplish the strategic goals and objectives in our Agency Strategic Plan (ASP). Our May 2012 Information Resources Management (IRM) Strategic Plan describes our IT

guiding principles and plans for systematically modernizing our infrastructure using sound and viable technologies. We are currently updating the fiscal year (FY) 2013 IRM Strategic Plan according to the guidance and timelines prescribed by the Federal Chief Information Officer. Our FY 2012 IRM Strategic Plan is available at http://www.ssa.gov/irm/index.htm.

We are now developing a number of projects that are critical for improving our efficiency and the quality of our service. For example, we expect to introduce the following self-service online applications soon:

- Internet Medicare Replacement Cards – Individuals will have the ability to request a replacement Medicare card online at their convenience and in a more secure environment. We anticipate releasing this application to the public in October 2013. The estimated cost for development is $1.5 million.

- Internet Replacement 1099 – Individuals will have the ability to request a replacement Social Security Benefit Statement (SSA-1099) online, at their convenience and in a more secure environment. We anticipate releasing this application in October 2013. The estimated cost for development is $2.5 million.

- Marriage of the iClaim Disability application with the Disability Report – We are streamlining the online process for applying for disability by providing a single point to access both the benefit application (iClaim) and the Revised Adult Disability Report (i3368). This enhancement should result in a faster disability decision for the claimant and time savings for us, because it will reduce our need to recontact individuals for additional information. Currently, individuals often provide either the iClaim or the i3668, and we must recontact them to get the missing document. We anticipate completing this application process in January 2014. The estimated cost for development is $4.6 million.

- Mobile wage reporting – We are currently piloting a mobile application which permits Supplemental Security Income (SSI) beneficiaries to report their wages. They will no longer need to call or visit a Social Security office to report wages. We are currently piloting the mobile application in 263 offices across the country and expect to expand it to the rest of the country in late summer 2013. The estimated cost is $5 million.

Additionally, it is my understanding that a number of information technology upgrades are underway. Please provide a comprehensive list of all the work underway and the upgrades under consideration as well as an estimate of both the amount of time required to complete those projects underway and the time required to complete the projects under consideration.

You can access a list of all of our current IT projects by going to the Federal IT Portfolio website at http://www.itdashboard.gov/portfolios/agency=016 and clicking the "investments" tab. The site also provides the status of and the estimated time to complete every project.

Finally, please provide the current balance available within the no-year IT account and explain what the agency intends to devote these funds to over the course of the current fiscal year and FY 14.

The total in the no-year IT account available for fiscal year (FY) 2013 is $161 million. Below is a list of major initiatives included in the IT budget funded by the Limitation on Administrative Expenses account and no-year IT. We are in the process of planning for FY 2014.

- IT Infrastructure: The IT Infrastructure initiatives assure the sustained operation of current IT systems and provide an environment to support the growth of our agency's new systems and technical infrastructure. The following are major IT Infrastructure initiatives:
  - Data Center Support
  - Office Automation
  - Telecommunications
  - Telephone Systems Replacement Project
  - National Support Center

- Core Services: Core Services develop seamless, integrated, customer-centric automation tools that support all service delivery channels and several of our agency's major business processes. The following are major Core Services initiatives:
  - Citizen Access Routing Enterprise Through 2020 (CARE Through 2020)
  - Medicare Modernization Act Project
  - eServices (formerly Online Claims)
  - Earnings Redesign
  - Title II Redesign
  - SSI Modernization

- Disability Process: Disability Process investments support the administration of SSA's disability programs and allow our employees to provide quality service that is responsive to the needs of persons with disabilites. The following are major Disability Process initiatives:
  - Disability Case Processing System (DCPS)
  - Disability Determination Services (DDS) Automation
  - Intelligent Disability

- Security and Business Recovery: Security and Business Recovery investments implement security policies and procedures within our IT environment. These investments will ensure that we protect our IT resources from internal and external user threats, such as unauthorized access, misuse, damage, or loss.

- High Performing Workforce: High Performing Workforce initiatives improve the productivity, efficiency, and quality of our human resource systems and services. Interactive Video Teletraining is an example of a major High Performing Workforce initiative.

- Program Integrity: Program Integrity investments support our goal of preserving the public's trust in our programs. Our Program Integrity goals are to: minimize improper payments; automate the collection of death information; increase the electronic filing of wage reports and improve earnings record accuracy; strengthen our ability to protect program dollars from fraud, waste, and abuse; ensure that internal control deficiencies affecting our financial statements are corrected; and ensure the safety of SSA's resources during emergencies.

- Enterprise Architecture and Planning: Enterprise Architecture and Planning investments provide support services, hardware, and software needed to design, develop, and document enhancements to our Enterprise Architecture and explore promising technologies.

- Financial Management Systems: Financial Management Systems investments support our compliance with applicable accounting principles, standards, and related requirements; management control standards; and Federally-prescribed policies. Our financial accounting system is the only major investment in the Financial Management Systems area.

- Hearings Process: Hearings Process investments promote and manage IT projects that directly advance efforts to eliminate the hearings backlog and prevent its recurrence.

STRATEGIC PLAN

In light of all the management challenges and budgetary uncertainty SSA is facing, we directed SSA in the FY12 Omnibus to work with the National Academy of Public Administration (NAPA) to produce a long-range strategic plan. The Subcommittee believed it was crucial that this strategic plan include the input of an external body competent in addressing complex management challenges within the public sphere. In spite of claiming that SSA cannot work with NAPA unless they were selected through a fair and open competition, you all have not taken any steps to compete a contract for this work. While there may be value in establishing a shorter term service delivery plan, such a plan cannot take the place of a true long-range strategic plan.

Acting Commissioner Colvin indicated at our recent hearing that she was prepared to review the decision to not move forward on producing a strategic plan in partnership with NAPA. Please explain the steps the Acting Commissioner intends to take to fulfill this commitment over the course of the current fiscal year. We expect to be informed in the response to this question: a) whether the Commissioner intends to produce a true long-range strategic plan and the timeframe for doing so, and, b) whether the Commissioner intends to include NAPA in the effort to produce such a plan. If not, please address whether SSA intends to open up a competition to contract with an outside group for this work.

I am pleased to announce that I recently designated Ruby Burrell as our Chief Strategic Officer and Performance Improvement Officer. Ms. Burrell is an innovative, strategic thinker who has

envisioned and led some of the most transformational initiatives at SSA. She led our effort to move from paper to electronic disability claims processing and developed the vision and strategic plan for our Disability Case Processing System (DCPS), which I mentioned in a response to a previous question. DCPS will replace the five legacy systems used by our State DDS partners.

Ms. Burrell will lead the agency-wide effort to develop a long-range strategic plan with a three-to-five-year time horizon that will integrate IT, service delivery, and human capital plans. Ms. Burrell reports directly to the Office of the Commissioner. Together and with the support of our talented leaders at our agency, we plan to build a culture that encourages and fosters strategic thinking. We expect to complete the long-range plan by February 2015 and to release it with the President's Budget for Fiscal Year 2016. We will engage with employees, advocates, Congress, and other stakeholders in the process.

In addition to embarking on a new long-range planning initiative, we are currently updating our existing Agency Strategic Plan, which spans 2013-2016. As required by the GPRA Modernization Act of 2010, our updated plan will cover the period 2014-2018. I established an Executive Steering Committee to oversee the process, and we have a dedicated group of skilled employees working to gather input from the public and build engagement within our agency and with our external stakeholders. We also look forward to getting input from Members of Congress. We have asked for suggestions for innovative and efficient ways to accomplish our core mission in this environment of constrained budgets and increasing service demands. We expect to update this plan by February 2014 and to release it with the President's Budget for Fiscal Year 2015.

I believe that strategic planning expertise would be valuable in defining a forward-looking plan. We would welcome the participation of an entity like NAPA in the development of our long-range plan. We currently are considering our options for accomplishing this.

Congressman Mike Simpson

1. I am aware that SSA has been employing data analytics and predictive analysis with positive results in the Quick Disability Determination program and the Compassionate Allowance program. Can you please provide me with information on the reductions in processing times overall, the average per case, and the QDD success rate.

The success of our Quick Disability Determination (QDD) and Compassionate Allowance (CAL) processes is reflected in several ways, including faster processing time and highly accurate decisions. In FY 2012, we selected approximately 5.8 percent of our initial disability cases for the QDD and CAL processes. The DDSs processed these cases in an average of 10.8 days, which is significantly faster than the DDS average time of 82.9 days for all initial disability claims.[1] The accuracy of our QDD and CAL cases is in line with the DDS decisional accuracy of 97 percent for all initial disability decisions. Approving clearly eligible claimants early in the

[1] These processing times reflect the DDS work performed at both State and SSA agency offices. We have very rare situations where locations other than a DDS (such as a Program Service Center) act as a DDS and process CAL and QDD cases as well as other disability claims.

process helps persons with severe disabilities and, at the same time, allows us to focus our attention on the more ambiguous cases. While we can provide processing times for our disability cases, we are not able to isolate or quantify the effect that the QDD and CAL processes have on reducing the processing times for other disability cases.

2. Do you plan to incorporate similar tools in the newly developing Disability Case Processing System?

Yes, the DCPS currently receives the QDD indicators and CAL flags, which identify the cases for expedited processing. We will continue to utilize confidence scoring and predictive modeling throughout our case development. In addition, our Electronic Claims Analysis Tool (eCAT) contains "intelligent pathing" and quality checks to assist the user in addressing critical policy issues relevant to the disability claim. We plan to continue enhancing eCAT and will incorporate additional functionality into DCPS.

3. Please provide me information on the status and future plans for greater use of predictive analytics for the: Ticket to Work program, Office of Disability Adjudication and Review, and SSI redetermination reviews

Ticket to Work Program

Predictive analysis helps us find ways to more effectively utilize our Ticket to Work (TTW) program resources and still target beneficiaries who are most likely to return work. By analyzing our data, we determined we could effectively target Ticket mailings to the beneficiaries who are most likely to use them, instead of automatically mailing Tickets to all beneficiaries. Our model showed we could contact fewer than half of new beneficiaries and still reach most of the beneficiaries who would eventually use a Ticket. Beneficiaries not automatically mailed a Ticket would still be eligible to participate in the TTW program.

In January 2012, we initiated a targeted auto-dialing project. Each month, we make about 20,000 automated calls to beneficiaries selected by the predictive model. Since the project started, about 22 to 25 percent of those called every month stay on the line to speak to a representative or call back to obtain more information about the TTW program.

Office of Disability Adjudication and Review

In our Office of Disability Adjudication and Review (ODAR), we use predictive analysis in a variety of ways to improve efficiency and offer improved public service. For example, we are using predictive analysis to identify hearing requests that can be decided by senior attorney adjudicators or informally remanded to the DDS, thereby saving scarce administrative law judge time for more complex cases. We also developed a model that predicts the time required to process cases in each hearing office and identifies transfers we can make between hearing offices to balance our workloads across the nation. The Office of Appellate Operations (OAO) also used predictive analysis to develop productivity standards for employees, and we are using the same model to create similar standards at the hearing level. These standards allow us to predict production more accurately.

Our additional efforts to employ analytic tools to improve ODAR's business processes include:

- Using structured data to create "heat maps" that identify patterns in how we process cases at the hearing and appeals levels. We then use these patterns to improve consistency in adjudication, highlight areas for more training, and identify policies that need revision;

- Developing the "Case Context Tool" to find patterns and anomalies in processing and dispositions among similar claims;

- Developing the "Case Status Change Model" to estimate the time a claim spends in each step of the hearing process in a hearing office. This information will be useful in designing predictive models of case flow through ODAR; and

- Exploring whether we can use "clustering analysis" in OAO to improve efficiency and quality by assigning cases involving similar issues to the same employee.

SSI Redeterminations

We are in the beginning stages of exploring the use of third-party data to enhance the efficiency and effectiveness of the predictive model we use to identify SSI beneficiaries who have likely received too much in SSI benefits. We use this information to schedule and prioritize redeterminations for SSI beneficiaries with the greatest likelihood of overpayment. We will soon publish a Request for Information to learn more about what useful third-party data may be available.

4. I am aware that other agencies are using these tools to identify improper payments and patterns of fraud to alert investigators. Do you have plans to incorporate similar efforts?

Improper Payments

Yes. We plan to explore the use of data analytics offered by the Do Not Pay "Business Center" to prevent and detect improper payments, which would complement our current improper payment efforts. On April 12, 2012, the President issued a memorandum, *Reducing Improper Payments Through the "Do Not Pay List,"* which directed Executive Agencies to take immediate steps to use the centralized solutions in place for pre-payment eligibility review. The Improper Payments Elimination and Reduction Improvement Act of 2012 further directs agencies to use Do Not Pay for pre-payment verification. We are evaluating the following potential uses, contingent upon available resources, of Do Not Pay's data analytics:

- Investigating situations in which unusually high numbers of payments are going to the same address or the same depositor account number;

- Identifying frequent or suspicious patterns of direct deposit account changes; and

- Verifying the suitability of organizational representative payees.

Additionally, we developed a statistical model that predicts the likelihood of beneficiaries being at risk of receiving large overpayments due to work. This model prioritizes Continuing Disability Review Enforcement Operation (CDREO) alerts according to the likelihood of a "critical" overpayment ($20,000 or more). The model factors historical earnings, prior CDREO alerts, previous benefit increases due to earnings, overpayments, amount of monthly benefits, time on the rolls, and impairment codes. We are seeing early success in testing this model in two pilots.

Fraud

The Office of the Inspector General (OIG), Office of Audit (OA) is using data analytics to identify improper payments in the Social Security and SSI programs. The OA employs a team of IT Specialists who extract data from SSA's various systems—including the master beneficiary records as well as enumeration, earnings, and death data—in search of errors, problems, and trends. OIG auditors conduct audits using the results of the data analysis to quantify improper payments, identify the root causes of the errors, and make recommendations to our agency to prevent future payment errors.

In addition, the OIG, Office of Investigations (OI) is in the developmental stages of creating an Electronic Intelligence Center within its Forensic Intelligence and Analysis Division. One of the functions of this Center will be to perform predictive analytics. Initially, the Center will develop its predictive analytics algorithms based upon the successful outcomes of the cases contained within its National Investigative Case Management System. These algorithms will then be applied to new, incoming allegations with the goal of focusing the OI's efforts on those allegations that show the most promise. Ultimately, those predictive analytics algorithms will be developed to the point where they can be applied to SSA's new, incoming claims for benefits with the goal of alerting potential fraud before it starts.

Congresswoman Barbara Lee

Constrained Budget

In your testimony you spoke about the challenges SSA is facing due budgetary constraints, the challenges you are facing due to sequestration, and the fact that the funds appropriated have been lower than the funds requested by the Commissioner and the President.

Question 1: What more would you have been able to accomplish had you received the funding requested in the President's FY 2013 Budget?

Our funding level for FY 2013 (post-sequestration) is $11.046 billion. Our President's Budget request for FY 2013 was $11.760 billion. If we had received the FY 2013 President's Budget we would have been able to mitigate much of the degradation of service described in my testimony and work towards improving service and stewardship. Under the President's Budget, we estimated that we would complete over 650,000 full medical continuing disability reviews

(CDR) in FY 2013. Instead, with the reduced funding that we received, we estimate that we will complete only 422,000 full medical CDRs. In FY 2013, we estimate that every dollar spent on CDRs will yield about $9 in program savings over ten years, including Medicare and Medicaid program effects. We would have been able to replace our losses through one-for-one hiring which would have allowed us to relieve the burden on critically understaffed field offices, the State DDSs, and our teleservice centers. We also would have been able to provide a considerable amount of overtime, comparable to the last two years, to help reduce backlogs of initial claims and hearings. We would have looked at resuming the full mailing of the Social Security Statement.

We are experiencing significant challenges stemming from three consecutive years of funding levels that were nearly a billion dollars below the President's Budget Requests. Tighter budgets, including cuts due to sequestration, have exacerbated our ability to serve members of the public who need our services, resulting in growing backlogs and longer wait times. Due to reduced staff and overtime, we estimate that:

- Callers to our 800-number will wait almost 45 percent longer in FY 2013 than in FY 2012;
- The average busy rate will rise from approximately five percent in FY 2012 to 16 percent by the end of FY 2013;
- The pending levels of initial disability claims will rise from 708,000 in FY 2012 to 804,000 at the end of FY 2013, an increase of nearly 100,000 claims; and
- On average, applicants will have to wait a week longer for a decision on an initial disability claim and nearly a month longer for a disability hearing decision compared to last year.

Question 2: Please explain to me what happens if funding for your program integrity activities are reduced?

Our program integrity funding has already been reduced. We currently expect to handle 422,000 CDRs, more than 200,000 below the amount authorized under the Budget Control Act and our FY 2013 President's Budget request, which is less than we accomplished in FY 2012. We plan to complete the same level of SSI non-disability redeterminations as we did last year, 2.622 million. For the FY 2013 President's Budget, we estimated that every dollar spent on CDRs will yield about $9 in program savings over ten years, including savings accruing to Medicare and Medicaid. For the FY 2013 President's Budget, we estimated that every dollar spent on SSI redeterminations will yield about $6 in program savings over ten years, including savings for the Medicard program.

Despite enactment of multi-year discretionary cap adjustments, the annual appropriations process has not provided the full amount of program integrity funding authorized in the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. Tens of billions of dollars in deficit savings over the next ten years from curtailing improper payments will not be realized if sufficient funding for the administrative expenses for our program integrity activities is not

provided. To ensure these important program integrity investments are made, the FY 2014 President's Budget includes a legislative proposal that would create a new Program Integrity Administrative Expenses Account in order to provide a reliable stream of mandatory program integrity funding. In FY 2013, the request is for an additional $266 million in mandatory funding, which would allow us to handle significantly more CDRs.

Staffing Shortfalls and Cuts in Service Hours

Thousands of skilled, experiences SSA employees have been lost through attrition and have not been replaced, resulting in an increased workload for the remaining employees.

Question 1: How many people visiting the field offices – whether claimants or those who simply need to replace a lost Medicare card – are denied service daily due to insufficient staffing?

SSA has been forced to reduce hours. You close an hour early every day, and on Wednesdays your offices are open for only 3 hours (from 9 to noon). In addition to this overtime has been largely eliminated, so employees are being asked to do more with less.

I want to be clear that we do not turn people away; we serve every person who comes through our doors during office hours. But years of funding below the President's Budget request level, combined with the sequester have made it increasingly difficult to provide service of the quality we pride ourselves on and the American public expects. Visitors have had to wait longer for us to see them. This fiscal year, the percentage of visitors who leave our offices without receiving any service from us increased from five to six percent per month. We do not know the exact reasons why these visitors left, but certainly many did so in frustration at the length of time they would have waited.

Question 2: How has this affected service, and what appropriation would be sufficient to restore the ability of the field offices to operate at full capacity?

As you noted above, we cut our office hours. We are now operating with nearly a billion dollars less than we had in FY 2010, the last fiscal year in which we operated with unreduced office hours. As early as FY 2011, we began to experience the adverse effect of attrition in our offices. Because of the recent reduced appropriations, we have been unable to replace lost staff or offer enough overtime to catch up. We started closing our offices early in order to better keep up with existing workloads.

This fiscal year, visitors without an appointment have had to wait, on average, nearly 26 minutes for us to see them, about 40 percent longer than in FY 2011. Not only has the average national wait time increased, but the number of visitors without an appointment who must wait a long time—30 minutes or more—for us to see them has increased from approximately 20 percent in FY 2011 to 36 percent this fiscal year. In some of our busiest offices with the most staff losses, the typical visitor without an appointment waits for longer than two hours for service. The American public deserves better.

Question 3: How many fewer appointments are being scheduled, and how does it impact walk-ins?

Comparing FY 2011 to this fiscal year, we are scheduling an average of 1,000 fewer appointments per day. However, this decrease alone does not adequately capture the fallout we experience in other service areas when there are fewer people in our office to secure appointments. We have a harder time scheduling people in a timely manner. We have historically scheduled approximately 90 percent of appointments within three weeks of receiving a request. However, since January of this year, we have scheduled only about 70 percent of appointments within three weeks of receiving a request.

Another consequence of people not being able to schedule a timely appointment is the increase in people choosing to walk in rather than wait so long for an appointment. While we cannot quantify how many do not make appointments, we know it affects our ability to serve walk-ins. I have described in my responses above the increase in the average wait time for walk-in service and the percentage of people who leave our offices without being seen. Additionally, to date in FY 2013, an average of 7,600 visitors coming to our field offices each week have to wait over two hours for service, a figure that increased 176 percent since FY 2011.

Impact of Sequestration

You mentioned the sequester in your testimony, and after hearing the budgetary constraints you are already operating under, it is very hard for me to imagine where further cuts could be made.

Please describe the actions that you anticipate taking as a result of sequestration.

Question 1: How many employees do you anticipate furloughing?

We do not expect to furlough any employees this year. As I noted in my written statement, we have been painfully frugal. We severely restricted overtime and we have postponed all hiring with the exception of a small number of staff hired to fill critical, front-line service positions. By the end of this year, we expect to lose an additional 3,300 employees through attrition on top of the 9,200 we have already lost since the beginning of FY 2011—a total loss of nearly 15 percent of our workforce.

As I answered to a previous question, our service to the public has suffered because of these losses. We expect that callers to our 800-number will wait almost nine minutes for us to answer, nearly twice as long as in 2012. The average busy rate will more than triple to 16 percent by the end of FY 2013. Pending initial disability claims will rise from 708,000 to 804,000 from the beginning to the end of FY 2013, an increase of nearly 100,000 claims. On average, applicants will have to wait a week longer for a decision on an initial disability claim and nearly a month longer for a disability hearing decision compared to last year.

We also must reduce the number of CDRs we complete to 422,000, more than 200,000 fewer than the FY 2013 President's Budget request and fewer than we completed in FY 2012. This

reduction is particularly worrisome because CDRs are so cost effective; for every $1 we spend doing a CDR, the taxpayer saves $9 over 10 years. These and other cuts to our program integrity efforts achieve short-term savings at the price of long-term costs.

Question 2: How many fewer claims will be processed?

We expect to handle 2,962,000 initial disability claims this year, 245,000 fewer than we handled in FY 2012.

Question 3: How will the backlog be affected?

We expect that the pending level of initial disability claims will grow from 708,000 in FY 2012 to 804,000 by the end of FY 2013, an increase of nearly 100,000 claims. On average, applicants will have to wait a week longer for a decision on an initial disability claim and nearly a month longer for a disability hearing decision compared to last year.

Question 4: How much longer will people have to wait for their initial appointment?

As I answered to a previous question, we now schedule about 30 percent of all appointments more than three weeks from the date of the request. Historically, we have scheduled less thanten percent of all appointments more than three weeks from the request. We do not project how many more people will have to wait for longer than three weeks for the next available appointment, but we do not expect the length of the delays to improve under our current budget constraints.

SOCIAL SECURITY

Office of Retirement and Disability Policy

July 15, 2013

The Honorable Sam Johnson
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your May 14, 2013 letter requesting additional information to complete the record for the hearing on disability decisions. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

Arthur R. Spencer
Associate Commissioner
for Disability Programs

Enclosure

Questions for the Record
For the March 20, 2013 Hearing
On Disability Decisions
Questions from Chairman Johnson

1. **In your testimony, you indicated that the Social Security Administration (SSA) has an interagency agreement with the Bureau of Labor Statistics (BLS) to test occupational data collection methods that could lead to the development of a new Occupational Information System to replace the long outdated Dictionary of Occupational Titles (DOT).**

   a) **How much will SSA spend on the interagency agreement with BLS from start to finish? What is the timetable for testing and use of the new system if testing is successful? When will adjudicators have a tool in their hands they can use?**

   At this time, we cannot provide actual costs because those costs will depend on the results of ongoing feasibility testing. Last fiscal year (FY), we spent $392,000 on the interagency agreement. This fiscal year, we anticipate spending $10.8 million. We anticipate spending $14.8 million in FY 2014 and $16 million in FY 2015.

   Our timetable for the new system is as follows:

FY 2013	• At the beginning of this fiscal year, BLS began implementing its data collection test plan.
FY 2014	• BLS will continue testing any outstanding issues and will conduct a small-scale production test to prepare for the full-scale data collection. The small-scale production test will not include a full sample and will be based on the FY 2013 testing result.
FY 2015	• Depending on FY 2014 small-scale production test results, BLS may begin gathering full-scale production data, some of which may be available in FY 2016. • After full-scale production data is complete, we will test the effects of using the data in our adjudicatory process prior to full-scale implementation.

   Adjudicators may be able to use the new occupational information system (OIS) as early as FY 2016. This date depends on the results of the small-scale production test, the gathering of actual production data, and testing the production data in our adjudicatory process.

   To be clear, we are working with BLS to develop current occupational data for use in our disability programs. BLS is not updating or replacing the DOT.

b) When did efforts to update the DOT begin? How much funding has been spent to date?

The OIS project began in FY 2008 with initial research exploring whether the Department of Labor's Occupational Information Network (O*NET) or other occupational classification systems could meet our disability evaluation needs. We determined that neither O*NET nor any other then currently available system would be able to meet our requirements without modification. From FY 2009 to FY 2012, we convened the Occupational Information Development Advisory Panel (OIDAP). The OIDAP consisted of experts in industrial and organizational psychology, worker rehabilitation, and disability program law. The OIDAP made recommendations to us regarding OIS development and held regular public meetings that allowed stakeholders to share their advice and concern regarding the development of our OIS. In July 2012, the charter for the OIDAP expired and we entered into an interagency agreement with BLS to help support the development of new occupational data for us.

From FY 2008 through FY 2012, we spent roughly $3.8 million on the OIS project.

OIS Spending by Fiscal Year

Fiscal Year		Spending
2008	$	665,000
2009	$	342,000
2010	$	815,000
2011	$	990,000
2012	$	984,000
Total	$	3,796,000

Please note that the FY 2012 figure includes the $392,000 that we spent on the interagency agreement with BLS.

2. What standard qualifications are in place for vocational experts used by the DDSs and/or used by the Administrative Law Judges (ALJs)? How are they trained?

At the State level, disability determination services (DDS) agencies do not use vocational experts (VEs). Instead, they use vocational specialists who know how to apply vocational factors to a specific medical-vocational determination. Using its own personnel standards, each State DDS determines which employees qualify as vocational specialists.

Regarding vocational specialist training, we have developed a wide variety of vocational training resources that any DDS adjudicator can access directly from his or her personal computer workstation. These training resources include PowerPoint slides, desk guides, online case studies, and numerous videos on demand (VOD). We have also converted a previous three-day headquarters "Vocational Specialist" training into a series of VODs that DDS employees can access at their workstations called "Vocational Specialist at the Desktop" training. This series provides DDS employees with training on complex vocational

policy areas, such as residual functional capacity, remaining occupational base, and Steps 4 and 5 of the sequential evaluation process.

At the hearing level, we use VEs. VEs are independent contractors. To qualify as a VE, a contractor must be trained and skilled to render impartial opinions relevant to evidence at the hearing level of the disability claims process. A VE should have current knowledge of the following:

- working conditions and physical demands of various occupations;
- transferability of skills;
- the existence and number of jobs at all exertional levels in the national economy; and
- job placement for workers with disabilities.

The VE should also possess the following:

- up-to-date knowledge of, and experience with, industrial and occupational trends and labor market conditions;
- an understanding of how we determine whether a claimant is disabled;
- current and extensive experience in counseling and job placement of people with disabilities; and
- knowledge of, and experience using, vocational reference sources. These sources include the DOT, County Business Patterns by the Bureau of the Census, the Occupational Outlook Handbook published by BLS, and any occupational surveys of occupations prepared for us by various State employment agencies.

Because VEs are independent contractors, we do not provide their training. However, we have developed a VE orientation PowerPoint presentation that our regional offices share with their VEs.

3. Is there a process in place for the SSA to respond to recommendations from the Administrative Conference? If yes, please describe.

Once we receive a report and recommendations from the Administrative Conference of the United States (ACUS), our internal components with the related subject matter expertise perform detailed reviews of the report and conduct any necessary additional research. The components work together to evaluate which of ACUS' recommendations best address the issue or area of concern that we asked ACUS to study, while simultaneously weighing the challenges that we face in the current environment. The components will reach agreement on the best course of action, which may or may not include implementing the ACUS recommendations or versions of the recommendations.

4. **Since 2003, Social Security's disability programs have remained on the Government Accountability Office's high-risk list because they rely on out-of-date criteria in making disability benefit decisions. Social Security is in the process of performing comprehensive updates of each of the fourteen body systems in the Listing of Impairments used to determine if someone is disabled, but some of the reviews have been ongoing for the last 19 to 33 years. Two of the listings, mental and neurological disorders, have not been comprehensively revised for more than 27 years. Why the delay? In addition, please provide a table which provides detailed information regarding the status of each listing update. Please also include a summary of the process for how listings are updated.**

   We are currently revising our Listing of Impairments (Listings) governing the evaluation of mental and neurological disorders through the multi-step rulemaking process. These revisions will reflect current medical knowledge and practices, advances in medical technology, and our adjudicative experience.

   We have made a commitment to update all of our Listings, recognizing that some Listings have not been updated in many years. These Listings are complicated, and we want to make sure that we revise them correctly. To some extent, the complexities of certain body systems, such as mental and neurological, have caused the delays in updating the corresponding Listings.

   I have enclosed a chart that provides the status of each Listing update (Enclosure 1) and a summary of the process for how we update Listings (Enclosure 2). Please note that the chart reflects the anticipated dates of publication as published in the fall 2012 Unified Agenda. We will be making some changes to the anticipated dates of publication for some of the Listings, and these changes will be published in the spring 2013 Unified Agenda.

5. **Please explain why, in Fiscal Year 2012, the Puerto Rico Disability Determination Services (DDS) awarded benefits 59.1 percent of the time, when Mississippi DDS awarded benefits 25 percent of the time.**

   Our research indicates that factors outside of the DDS' or our control substantially affect State-to-State variation in allowance rates. These factors include the composition of initial determinations by age, gender, primary diagnosis, and the presence of a secondary diagnosis. Claim filing rates also vary from State-to-State, and this can significantly affect allowance rates. Historically, States with high filing rates tend to have low allowance rates and vice-versa. Other State characteristics, such as economic conditions, demographics, and health levels, correlate strongly with the filing rate. Consequently, these characteristics indirectly influence the allowance rate.

   In addition, there is no Supplemental Security Income (SSI) program in Puerto Rico, so its allowance rate is only for Social Security Disability Insurance (SSDI) claims. SSI determinations tend to have a much lower allowance rate and pull down a State's overall allowance rate. Other States with SSDI allowance rates that are comparable to Puerto Rico include Wyoming.

New Hampshire, New Jersey, South Dakota, Vermont, North Dakota, and Massachusetts; these States have allowance rates that range from roughly 62 to 50 percent. The national allowance rate for FY 2012 for SSDI claims is 42.5 percent.

6. **What responsibilities does a claimant have in the development of their claim and in the appeal of a previous decision? What responsibilities does the agency have? Are these responsibilities required by statute, regulation, or agency policy?**

Regardless of the level of adjudication, the Social Security Act (Act) and our regulations make proving disability the claimant's responsibility. The Act requires a claimant to provide medical and other evidence showing that he or she is disabled. Section 223(d)(5)(A) of the Act, 42 U.S.C. 423(d)(5)(A). See also section 1614 of the Act, 42 U.S.C. 1382c(a)(3)(H)(i) (applying the provisions of section 223(d)(5) to disability determinations under title XVI). Our regulations specify that a claimant must provide evidence, without redaction, showing how his or her impairment(s) affects his or her functioning and any other information that we need to decide the claim. Our regulations further require a claimant to provide, if we request it, evidence regarding non-medical factors that demonstrate how a claimant's impairment(s) affects his or her ability to work (such as activities of daily living). 20 C.F.R 404.1512(c) and 416.912(c).

The Act also requires us to develop a complete medical history of at least the preceding 12 months before we deny a disability claim. When deciding a disability claim, we must make every reasonable effort to obtain the medical evidence that we need from the claimant's medical sources. Section 223(d)(5)(B) of the Act, U.S.C. 423(d)(5)(B). See also section 1614 of the Act, 42 U.S.C. 1382c(a)(3)(H)(i). If the claimant's medical sources cannot or will not give us sufficient medical evidence to decide the claim, our regulations allow us to purchase a consultative examination or test. 20 C.F.R. 404.1517 and 416.917.

7. **What are the qualifications for a DDS examiner? How does Social Security ensure that training is provided consistently nationwide to DDS examiners? What professional development and continuing education opportunities are offered to ensure examiners have the skills needed to make decisions effectively?**

Each State DDS determines which employees qualify as examiners pursuant to its own personnel standards, and the professional development and continuing educational opportunities offered to its examiners. We do not provide specific professional development and continuing educational opportunities, but we provide policy-compliant training materials on all aspects of the disability program. We also provide training materials to address new or updated policy, processes, initiatives, and quality trends. We design our training to meet the needs of all staff and address State-specific needs. All of our training materials are readily available to all DDSs via our Intranet, VODs, and video conferences. In addition, we provide training through other formats, such as on-site training.

8. **At this Subcommittee's March 13, 2013 hearing, we learned that some people are receiving benefits for as many as 12 years on average. If a person was determined to be disabled 12 years ago and their condition has not changed, but they would not qualify for disability under today's standards, what happens?**

In your scenario, we would most likely continue benefits even if the beneficiary would not qualify under today's standards. When conducting a continuing disability review (CDR), the Act requires us to use the Medical Improvement Review Standard. When applying this standard, we begin by comparing the beneficiary's current condition to the findings related to that condition when we last found the beneficiary disabled. Thus, we would compare the beneficiary's current condition to findings from 12 years ago. Before we terminate eligibility, we would have to show:

- medical improvement in the beneficiary's condition;
- increase in their ability to perform basic work activity; and
- ability to engage in substantial gainful activity.

However, there are exceptions to this rule. For example, if the beneficiary became eligible through fraud, we would immediately re-determine that eligibility even if the condition were unchanged.

9. **Recently, Social Security changed the process for determining if a person can work by having examiners look at jobs in the national economy before looking at past work. Please explain the policy and why it was implemented.**

In July 2012, we issued regulations that gave adjudicators the discretion to proceed to Step 5 of sequential evaluation when we have insufficient information about a claimant's past relevant work history to make a finding at Step 4. We implemented this policy to expedite cases in which the adjudicator currently does not have sufficient vocational evidence to evaluate work at Step 4 but is able to deny the claim at Step 5. Vocational development can be extremely time-consuming, and this expedited process can save valuable processing time by appropriately making a "not disabled" determination at Step 5. Of course, if we find that the claimant may be unable to adjust to other work at Step 5 or if one of our special medical-vocational profiles may apply, the adjudicator will return to Step 4 to develop the claimant's work history and make a finding about whether the claimant can perform his or her past relevant work.

Our revised policy states:

- If there is enough vocational evidence in the file to find that the claimant can perform at least one past relevant job (either as he or she performed it or as it is generally performed in the national economy), the adjudicator should deny the claim at Step 4 of sequential evaluation.

- If there is not enough vocational evidence to determine whether the claimant is able to perform past relevant work, the adjudicator may either develop the vocational

evidence to evaluate the claim at Step 4 or proceed to Step 5. Before using the expedited process, the adjudicator will first consider whether any of the special medical-vocational profiles might be applicable.

- If the adjudicator can determine that the claimant can adjust to other work in the national economy, he or she will deny the claim at Step 5.

- If the adjudicator cannot deny the claim at Step 5, he or she must return to Step 4 and develop the needed vocational evidence regarding past relevant work.

10. A paper recently released by Jeff Liebman and Jack Smalligan suggests temporarily switching Social Security's State DDS costs from discretionary to mandatory spending. They believe this change would provide the resources the agency needs to stay current with continuing disability reviews, better document claims at the initial application step, and reduce case backlogs. After 5 years, Social Security would have to demonstrate that the increased expenditures more than pay for themselves with reduced spending. What are the agency's views regarding this proposal?

Jeff Liebman and Jack Smalligan developed some interesting proposals related to the SSA disability program, which we are currently reviewing. Thus, we are not ready to offer views on the specific proposals relating to the future of DDS funding.

However, on a similar idea relating to mandatory funding, the President's Budget for FY 2014 includes a special legislative Administration proposal that would provide a reliable stream of mandatory funding to significantly ramp up our program integrity work. Program integrity work ensures that only those eligible for benefits receive them.

The annual appropriations process has not provided us with the resources necessary to conduct all of our scheduled CDRs and redeterminations, leading to a backlog of 1.3 million CDRs. We estimate that each additional dollar spent on CDRs would save the Federal Government $9 and each additional dollar spent on redeterminations would save the Federal Government $5.

The proposal would create a new Program Integrity Administrative Expenses account, which would be separate from our Limitation on Administrative Expenses account. The new account would cover a substantial amount of our costs for CDRs and redeterminations over the next 10 years. If approved, the funds would be available for two years and would provide us with the flexibility to aggressively hire and train staff to support the processing of more program integrity work. The Budget proposal would lead to net savings of $38 billion over 10 years.

In FY 2014, the budget proposal would provide $1.227 billion, allowing us to handle significantly more CDRs. With this increased level of funding, the associated volume of medical CDRs is 1.047 million, although it may take time to ramp up to that level. For comparison, we conducted 443,000 CDRs in FY 2012.

11. The Inspector General's testimony highlighted findings from a July 2012 audit regarding administrative finality, indicating that the SSA agreed to review and evaluate administrative finality policies. What specific progress has been made?

We formulated several ideas for changing the rules of administrative finality. We intend to vet these ideas with external stakeholders, including the public.

Enclosures (2)

Enclosure 1 – The Honorable Sam Johnson

Status of the Medical Listings Revisions

Body System	Current Status
Growth Impairments NPRM*	NPRM published 5/22/13 at 78 FR 30249; public comment period closes 7/22/13.
Musculoskeletal System NPRM	NPRM drafted. Anticipated date of publication: 11/2014.
Special Senses - Vision final rule Special Senses - Hearing Loss and Disturbances of Labyrinthine-Vestibular Function ANPRM**	Final rule published 3/28/13 at 78 FR 18837. ANPRM drafted.
Respiratory System NPRM	NPRM published 2/4/13 at 78 FR 7968; reviewing public comments to begin drafting the proposed final rule.
Cardiovascular System NPRM	Drafting NPRM. Anticipated date of publication: 4/2014.
Digestive System NPRM	NPRM drafted. Anticipated date of publication: 6/2014.
Genitourinary Impairments NPRM	NPRM published 2/4/13 at 78 FR 7695; reviewing public comments to begin drafting the proposed final rule.
Hematological Disorders NPRM	NPRM drafted. Anticipated date of publication: 11/2013.
Skin Disorders NPRM	NPRM drafted. Anticipated date of publication: 12/2014.
Congenital Disorders that Affect Multiple Body Systems final rule	Final rule published 2/4/13 at 78 FR 7659.
Neurological NPRM	NPRM drafted. Anticipated date of publication: 12/2013.
Mental Disorders final rule	Drafting final rule.
Malignant Neoplastic Diseases NPRM	NPRM drafted. Anticipated date of publication: 3/2014.
Evaluating Human Immunodeficiency Virus Infection and Evaluating Functional Limitations in Immune System Disorders NPRM	NPRM drafted.
Language and Speech Disorders NPRM (proposed new Listing)	ANPRM published 2/6/12 at 77 FR 5734; Drafting NPRM. Anticipated date of publication: 11/2014.

*Notice of proposed rulemaking (NPRM)

**Advance notice of proposed rulemaking (ANPRM)

Business Process for Revising the Medical Listings

Background

The Listing of Impairments (Listings) revision process is an ongoing, multi-phase effort to update and revise the Listings, which describes, for each major body system, impairments considered severe enough to prevent an individual from doing any gainful activity, regardless of the individual's age, education, or work experience. In the case of children under age 18 applying for Supplemental Security Income (SSI), the listed impairments are severe enough to cause marked limitations in two domains of functioning or an extreme limitation in one domain. Most of the listed impairments are permanent or expected to result in death. For some impairments, the Listing includes a specific statement of duration. For all other Listings, the evidence must show that the impairment has lasted or is expected to last for a continuous period of at least 12 months. The criteria in the Listings are applicable for evaluation of claims for disability benefits under the Social Security disability program or payments under the SSI program.

The Listings are organized by major body systems—14 for adults (Part A) and 15 for children (Part B), although adult criteria can be applied to children if the disease processes have a similar effect on adults and children. We have over 100 listed impairments.

We update and revise the Listings to reflect the universal standard of care, as well as to include the latest advances in medical treatment and technology that affect a person's ability to function. The Listings also reflect our adjudicative experience through our own case reviews, the quality review system adjudicator feedback, as well as research and advocate input.

Listings Revision Process

There are five high-level phases involved in the Listings revision process: information gathering, drafting the Notice of Proposed Rulemaking (NPRM), completing the internal agency review process, publishing the NPRM in the *Federal Register* for public comment, and publishing the final rule in the *Federal Register*.

Since 2004, we have comprehensively updated approximately 70 percent of the listings and are on track to propose revisions in the *Federal Register* for all listings by the end of 2014. We are committed to completing targeted revisions of the Listings on a 5-year basis; the 5-year period starts after we complete the comprehensive body system revision.

Step 1: Information Gathering

Internal

Internally and almost immediately after a Listing is updated, disability claims adjudicators ask, and we respond to, questions about how to apply the recently updated medical criteria. We also review Request for Program Consultation (RPC) and Policy Feedback System (PFS) data to look

for trends in adjudicative practice that highlight the need for policy clarification. We developed the RPC process to resolve differences of opinions between adjudicators and quality reviewers concerning disability determinations. We post all RPC resolutions and related data on our Intranet to make them available to all agency staff. We use the information to identify issues and areas where we might improve disability policy. The PFS supports our initiative of improving disability policy by gathering data from the large amounts of programmatic information that we collect throughout the disability process and by using the data to identify areas for policy change and improvement.

We release a questionnaire to our internal users/adjudicators to solicit input about their experience using the revised medical criteria throughout a one-year period. In addition, our staff performs literature searches and research to learn about advancements and recent changes in medical treatment and technology.

External

One year after we implement revised medical criteria, we send a questionnaire to external advocacy and other interest groups to learn about their experience with the rules. The groups include patients, medical experts, technicians, clinicians, and the public. We maintain contact lists for each body system and a general contact list for our use to notify the public when our regulations are available in the *Federal Register* for public review and comment. Recently, we launched a test of an open government public engagement option to invite internal and external comments on an issue that will provide insight into our work to update and revise the Listings.

Formal Outreach

We conduct formal outreach by soliciting comments from the public and by meeting with advocacy and interest groups. We publish an Advance Notice of Proposed Rulemaking (ANPRM) in the *Federal Register* to provide information and pose specific questions that we believe will be helpful to solicit comments from the public that we can use to update and revise the Listings. In the past, we hosted public outreach conferences to give advocacy and other interest groups an opportunity to share their concerns and experience about certain impairments. Over the past four years, we have hosted these meetings internally or by teleconference due to budget constraints. We host these outreach meetings as needed and up to the point where we begin drafting the NPRM.

To keep the Listings medically up to date, it is critical that we get advice from independent medical experts in a variety of medical and clinical disciplines. We have partnered with the National Academy of Sciences (NAS), Institute of Medicine (IOM), to research the Listings and provide independent, unbiased, and authoritative medical and clinical advice. The IOM Committee of Medical Experts to Assist Social Security on Disability Issues is a standing multidisciplinary expert medical committee convened by the NAS. It provides us advice through meetings, workshops/symposiums, and Federal Advisory Committee Act (FACA)-compliant

consensus study committees. By having independent medical experts provide us with necessary updates, we maintain our objectivity, and by using FACA-compliant consensus study committees that include members that have clinical expertise in a particular body system, we quickly obtain publically available reports that provide us with advice and recommendations on improving the effectiveness of the Listings.

Under our previous contract which expired in December 2012, the IOM convened two consensus study committees (cardiovascular and immune/human immunodeficiency virus (HIV)) and produced two reports with 36 recommendations for improvements to the Listings that we use to evaluate cardiovascular disorders (28 recommendations) and HIV infection (8 recommendations). We have used these recommendations to draft NPRMs.

The current contract proposal provides for the continuation of an expert medical committee to advise the Commissioner on when we should revise the Listings to keep them up to date. For example, the first task order provides for a consensus study committee to evaluate our use of symptom validity testing in our disability evaluation process (including Step 3, at which we use the Listings) for both physical and mental impairments.

At the end of the information gathering phase and from all of the efforts outlined above, we compile a list of the issues and topics that we use to draft the NPRM.

Step 2: Draft NPRM

In the draft NPRM step, small teams consisting of medical policy analysts, medical officers, and other agency medical consultants, with occasional input from outside experts, work together to do research, analyze issues, and write regulations to update and revise the Listings. The body system lead analyst develops a work plan to conduct regular meetings to draft the NPRM. The team uses these meetings to draft proposed changes to the Listings (proposed medical criteria) and the introductory text (information that adjudicators need to use the Listings) and the preamble (explanation of changes to the Listings).

Before the team begins drafting the NPRM, they create an issue paper that contains the list of issues and topics that were compiled throughout the information gathering phase. The issue paper is used as a guide for the team to complete this phase of the process.

At the point where the team completes drafting the NPRM, we send the proposed rules to another agency component to review a number of previously adjudicated cases to learn about the potential impact of the proposed Listings. We analyze and summarize the case review impact and submit it to our Office of the Chief Actuary for its use to conduct a cost-benefit analysis for the agency.

Step 3: Complete Review Process

This step marks the beginning of the agency internal review process. Any ANPRM, NPRM, or proposed final regulation first undergoes an internal agency review. Then, we send the documents to the Office of Management and Budget (OMB) to obtain its review and approval to publish in the *Federal Register*. After OMB completes its review and approves the regulation, OMB returns it to the agency to obtain the Commissioner's signature before it is published in the *Federal Register*.

Step 4: Publish ANPRM/NPRM in *Federal Register* for Public Comment
The ANPRM/NPRM is published in the *Federal Register* for review and comment for usually 60 days. The public submits comments to www.regulations.gov.

Step 5: Publish Final Rule

In the publish final rule step, at the end of the NPRM public comment period, we review the public comments and consider them when drafting the proposed final rule. The proposed final rule undergoes an internal agency review. Then, we send the documents to OMB to obtain its review and approval to publish in the *Federal Register*. After OMB completes its review and approves the proposed final rule, it is returned to the agency to obtain the Commissioner's signature before it is published in the *Federal Register*.

We publish the final rule in the *Federal Register*, along with a summary of the public comments and how we addressed them. Simultaneously, we develop adjudicator training on the final rules to coincide with the rules' effective date.

Post-Hearing Questions for the Record
Submitted to Marianna LaCanfora

"Curbing Federal Agency Waste and Fraud:
New Steps to Strengthen the Integrity of Federal Payments"
May 8, 2013

From Chairman Thomas R. Carper

1) The SSA Office of Inspector General (OIG) has made recommendations to improve the accuracy and completeness of the DMF. For example, in its reports, *Title II Deceased Beneficiaries Who Do Not Have Death Information in the Numident,* (A-09-11-21171; July 2012), the SSA OIG detailed that approximately 1.2 million deceased beneficiaries were not captured on the DMF because SSA was unable to match the beneficiaries' personally identifiable information in its records. An additional report, *Title XVI Deceased Recipients Who Do Not Have Death Information on the Numident,* (A-09-12-22132; May 2012), found that over 180,000 deceased individuals had not been added to the DMF, even though these same individuals had been reported as deceased to the SSA Supplemental Security Records. Further, the Government Accountability Office (GAO) in its testimony highlighted some specific DMF errors, including 130 records where the date of birth was after the date of death, and 1,295 records where the age of death was between 111 and 129, certainly a significant overstatement of the number of Americans who live that long.

a) Please provide a timeline for actions SSA will take to implement the SSA-OIGs recommendations to improve the accuracy and completeness of the Death Master File.

Please see response below.

b) Please provide a timeline for actions SSA will take to address the GAO findings.

We have implemented a number of initiatives and have others planned. These initiatives will improve the consistency of death data in our records, provide death reporting management information (MI), and ultimately result in a complete redesign of our death processing systems. We believe that these initiatives will address concerns raised by both OIG and GAO. We include a brief timeline and description of the completed and planned initiatives below.

Completed Initiatives

- On July 21, 2012, we began collecting information that provides reliable MI for State death reports, which will help us improve the death reporting process. This MI will allow us to thoroughly analyze State death data and identify patterns and trends. For example, we will be able to calculate the number of reports we receive by State, and how many of those reports are not Electronic Death

Registration (EDR) reports. We will also be able to calculate the number of reports with errors and categorize those errors.

- On September 29, 2012, we implemented systems changes to prevent the adjudication of a claim if a discrepancy exists between the name/Social Security number (SSN)/date of birth/place of birth on the Numerical Identification File (NUMIDENT)[1] and the name/SSN/date of birth/place of birth shown on the claim. Our claims processing systems will not permit us to adjudicate a claim until we resolve the discrepancy and the identifying information, including death information, on the NUMIDENT and the claim match. This change improves the consistency between our payment records and the NUMIDENT, and, as the Death Master File (DMF) is an extract of the NUMIDENT, further increases the accuracy of the DMF.

- On December 8, 2012, we completed the first NUMIDENT death match to the Master Beneficiary Record (MBR) for Title II and the Supplemental Security Record (SSR) for Title XVI. This match compares death data on the NUMIDENT to all payment records contained in the MBR and SSR. The match helps ensure that we correctly terminate benefits when a beneficiary is deceased. Beginning June 17, 2013, we will perform this match monthly, and our field office personnel will resolve the discrepancies identified in the match and terminate benefits as appropriate.

Planned Initiatives

- Death Processing System Redesign – As resources allow, we will continue work on a complete redesign and modernization of our Death Processing Systems. In FY 2014, we will provide a new user interface for death reporting and collect new, comprehensive management information. While the match mentioned above will help us to clean up our current records, the new Death Processing Systems will help ensure—on the front end of the process—that death records are more consistent across our systems.

- Standard MI Reporting – Beginning in August 2013, we will release standard reports that will assist us in administering the reimbursable agreements under which the States share their death data with us. As resources permit, we will issue reports and maintain cumulative data that will help identify data anomalies (such as duplicate death reports) and errors.

[1] The NUMIDENT is our electronic database of our records of SSNs assigned since 1936.

c) **During the hearing, the SSA witness suggested that SSA should reach out to agencies to make them aware of the availability of the more comprehensive Death Master File that includes state supplied data. What steps to you plan to take to facilitate access to the complete DMF by the Department of Labor, the Department of Agriculture, and other benefit paying agencies that have statutory right to this data?**

We do not routinely reach out to other agencies to market the full DMF. However, as mentioned during the hearing, in November 2011 we did partner with the Department of Commerce's National Technical Information Service (NTIS) to notify the agencies that were purchasing the public file, distributed by NTIS, that they should contact us if they believed they should have access to the full file. (Please see Enclosure 2 for the notice we provided to NTIS to send to those agencies.)

Since that time, we have had discussions with numerous Federal agencies regarding access to the full file, including the Department of Labor (DOL) and the Department of Agriculture (USDA).

- In late 2011, we discussed the possibility of the Office of Workers' Compensation Programs (OWCP) at DOL procuring the full DMF. OWCP decided to continue its arrangement with NTIS, through which it obtains the publicly available death data, which we understand is sufficient for OWCP's purposes and is more cost effective than obtaining the full file from us.

- In January 2013, USDA's Farm and Foreign Agricultural Service requested access to the full DMF, and we approved this access. We are currently working to complete our exchange agreement.

The following Federal agencies listed below have also requested access to, or expressed an interest in receiving, the full DMF. Our status on these requests, as of May 2013, is provided below.

<u>Approved and Agreements Completed</u>:

1. Department of Defense (DoD), Manpower Data Center (MDC)
2. Railroad Retirement Board (RRB)
3. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS)
4. Department of Veterans Affairs (VA)
5. Office of Personnel Management (OPM)
6. Internal Revenue Service (IRS)
7. Pension Benefit Guarantee Corporation
8. HHS, Health Resources and Service Administration (through an agreement with CMS)

Approved but Agreement Not Completed:

9. Federal Retirement Thrift Investment Board – The draft agreement is under review.
10. HHS, OIG – While we approved the request, HHS OIG determined it wanted to look for a way to obtain the information at a lower cost.
11. HHS, Centers for Disease Control and Prevention (CDC) – CDC is looking into whether it can obtain death information under an agreement between HHS and us.

Still in Discussion or Not Pursuing:

12. USDA, National Agricultural Statistics Service – On December 6, 2012, the National Agricultural Statistics Service requested access to the full DMF. We are reviewing the request.
13. U.S. Coast Guard, Retiree and Annuitant Services, Pay and Personnel Center – In August 2012, we requested additional information regarding the purpose for which the Pay and Personnel Center intended to use the full DMF. To date, we have not received a response.
14. HHS, National Institutes of Health (NIH) – While we advised NIH that we have authority to disclose the State death data for research conducted by NIH, we stated that NIH would not have authority to re-disclose State death information to grantees conducting research on behalf of the Federal Government. Our last conversation with NIH was in June 2012.
15. DoD, Defense Finance and Accounting Service (DFAS) – DFAS wanted us to modify the method we use to transmit the DMF data to them. On September 21, 2012, DFAS advised us it was withdrawing its request.

Requests Not Approved:

16. U.S. Coast Guard National Maritime Center – The National Maritime Center requested access to the full DMF to verify mariners' life/death status before responding to next of kin or third party requesters. Section 205(r) of the Social Security Act (Act) does not authorize us to disclose State death records for that purpose.
17. Department of the Treasury (Treasury), Bureau of Public Debt, now known as the Bureau of the Fiscal Service (Fiscal Service) – The Fiscal Service requested access for the Do Not Pay (DNP) program. Section 205(r) of the Act does not authorize us to disclose State death records for that purpose. The President's Fiscal Year (FY) 2014 Budget contains a legislative proposal to expand Federal agency access to the full file, not only for purposes of DNP, but also for purposes such as public health and safety and tax administration.

Any Federal agency that would like to explore accessing the full DMF, which includes State death records, should submit a request to ogc.opd.controls@ssa.gov. We would be happy to review the request, and, once our Office of General Counsel determines that the requirements of section 205(r)(3) of the Act are satisfied, our Offices of Data Exchange, Systems, and Policy, will work with the agency to establish an Information Exchange Agreement covering terms, conditions, and reimbursement for the exchange. In the

future, we expect that our newly formed Office of Data Exchange will be our first point of contact for agencies seeking a data exchange.

From Senator Tom Coburn, M.D.

1) **Is SSA required to prescreen beneficiary payments through the Do Not Pay Initiative? If so, has SSA signed up for that program?**

The Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA) requires Federal agencies, including us, to prescreen their payments through the DNP program as appropriate. Currently, we meet the requirements under IPERIA because Treasury runs our payments through DNP and provides us with monthly reports of matches, which we then investigate.

We plan to enroll in DNP when the Fiscal Service's contract negotiations with The Work Number, a national payroll provider, are complete, and The Work Number is fully integrated in the DNP portal. We are interested in using wage information from The Work Number to prevent or detect improper payments for our benefit programs. We defer to Treasury, but understand it anticipates including The Work Number in the DNP portal in late calendar year 2015.

An additional complication is that Treasury has told us that each field office employee who needs access to The Work Number through the DNP portal—approximately 27,000 employees—would require separate access, and the portal cannot, at this time, handle that volume of users. Currently, we average about 62,000 hits per month against The Work Number. We need to ensure the DNP portal can accommodate both the volume of users, as well as the volume of requests per month.

2) **How much money has SSA paid to the states for Electronic Death Records in each of the last three fiscal years?**

We enter into contracts with the States to obtain EDR reports, and reimburse the States, on a per item basis and using a sliding scale, for each death report we receive through this process. We pay the most for the records we receive within just a few days of the individuals' deaths. We pay less for less timely records. We pay more for EDR records than for non-EDR records.

Below, we provide the total costs[2] paid to the States for EDR reports in FYs 2010, 2011, and 2012. These costs increase each year as more States begin using the EDR process and as the payments are adjusted upwards to reflect inflation.

FY 2010 - $2,265,228.37
FY 2011 - $3,055,449.54
FY 2012 - $3,423,571.28

[2] We also pay the States for the death records they send to us outside of EDR.

3) What specific changes in law would be required for SSA to provide the full Death Master File to other agencies, including Do Not Pay?

Section 205(r) of the Act limits our authority to disclose the full DMF for certain Federal and State purposes. We cannot provide the full DMF to agencies beyond the purposes currently set forth in section 205(r) of the Act. Congress would have to amend section 205(r) of the Act to include the specific agency or purpose for which it requires us to disclose the full DMF. Alternatively, Congress could draft legislation that does not amend section 205(r) of the Act, but that specifically authorizes additional disclosure(s) and includes language that exempts us from the limitations of section 205(r) of the Act by using language such as "notwithstanding section 205(r) of the Social Security Act."

4) How much would it cost for SSA to ensure the accuracy of the Death Master File?

No collection of data is going to be 100 percent accurate without the expenditure of large sums of money. At some point, the money spent to address the few remaining inaccuracies is far greater than the amount saved as a result of the corrections. As Mr. Werfel stated during the hearing, "There may be such inherent complexity in some of the Federal programs and operations that you get to a point where you start spending $2 to save $1 in order to weed out that final bit of error."

We believe the most cost effective way to ensure the greatest possible accuracy in the death reporting process, and therefore, the DMF, would be to fully implement EDR. EDR is a web-based data exchange application designed to allow a State's Bureau of Vital Statistics to verify decedent's SSN's using the internet prior to submitting reports of death. Through EDR, the reporting entity verifies the name and SSN of the deceased individual before sending the death information to us, ensuring that the death report is associated with the correct record. EDR results in more timely and accurate death reports. Although we reimburse the States for EDR reports, HHS has responsibility for funding EDR start-up costs. We discuss this process, as well the President's FY 2014 budget request, which includes funding for implementation of EDR, in our response to the following question.

5) How much would it cost to get EDR up and running in every jurisdiction?

We understand that HHS, through CDC, has responsibility for funding the States to assist in establishing EDR. Within CDC, the National Center for Health Statistics (NCHS) is responsible for collecting and disseminating national vital statistics. The President's FY 2014 budget request includes an increase for NCHS, a portion of which is to begin an effort to phase in full implementation of EDR in all States and other vital records jurisdictions. Although over half the States participate in EDR, implementation varies—some jurisdictions have no system, while others have a system with complete coverage. Therefore, we understand that the cost of full implementation in all jurisdictions is difficult to assess.

The National Association for Public Health Statistics and Information Systems, the professional association of State vital records and public health statistics offices, may be able to provide additional information.

6) **If Congress delays the disclosure of death information to the public for three years, how will SSA comply with its requirements under FOIA to provide that information?**

As Congress develops legislation to delay disclosure of the publicly available DMF, which does not include State death information, for 3 years, we recommend that such legislation be drafted to specifically exempt this death information from disclosure under the Freedom of Information Act (FOIA). With a specific exemption from disclosure under section 552(b)(3) of title 5, United States Code, we would be able to deny FOIA requests until the 3-year period had expired. Without a specific exemption, we would not be able to deny such requests and would be required by law to provide the information. We note that under the OPEN FOIA Act of 2009, any legislation enacted after October 28, 2009 that exempts information from disclosure under FOIA must also cite to FOIA Exemption 3, 5 United States Code 552(b)(3). Therefore, the legislation must specifically cite to FOIA Exemption 3 in order for the information to be withheld under this exemption.

The proposal in the President's Budget for FY 2014 to limit the release of Social Security death information includes such an exemption and would protect our death information from disclosure to the public for 3 years.

7) **If instead, Congress limits the public disclosure to the last four digits of the deceased individuals' Social Security Number, would the provision of that information satisfy SSA's obligations under FOIA?**
   a. **For example, if someone put in a FOIA request for the death records of a specific person, and SSA provided that information, but only included the last four digits of their SSN, would that satisfy its requirements under FOIA?**

Please see the answer to your question 6. If legislation were drafted to limit disclosure of a deceased individual's SSN to the last four digits and such legislation provided specific exemption under section 552(b)(3) of title 5, United States Code, then we would be able to satisfy a FOIA request in such a manner.

We would also note that legislation to limit the disclosure of the full SSN does not necessarily need to go in section 205(r) of the Act because, as it reads currently, section 205(r) of the Act mainly addresses State death information.

8) How much does each agency that currently receives the full Death Master File from SSA pay for access? For each agency, provide the total cost, the frequency that the agency updates its file, and in cases where the agency does not pay for access, describe the reciprocal information that agency provides to SSA.

In FY 2012, four Federal benefit-paying agencies paid a total of $123,800 for access to the full DMF. The table below shows the FY 2012 costs by agency and the frequency with which we sent the data. We defer to the receiving agencies with respect to the frequency with which they update their files with the information we send them.

Agency	Reimbursement	Frequency
IRS	$74,751	Full file annually and weekly updates
HHS, CMS	$32,599	Weekly updates
DoD, MDC	$8,225	Monthly updates[3]
RRB	$8,225	Monthly updates

We also provide the full file to two additional Federal benefit-paying agencies that do not reimburse us.

- Pursuant to section 5106 of title 38, United States Code, we provide the full DMF annually and with weekly updates to the VA at no cost.

- The OPM does not pay for access to the full DMF file, which we provide annually and with weekly updates. Instead, information is exchanged between our two agencies in a reciprocal relationship using matching agreements. We have several matching agreements with OPM, including an agreement for our agency to disclose death information to OPM and OPM to disclose civil service benefit and payment data to us. Agreements such as the ones we have with OPM are beneficial to our program administration. For example, section 205(k)(5) of the Act requires us to offset certain Social Security benefits by a percentage of a non-covered pension, such as a civil service pension. We use the match results to meet these offset obligations. We also use information from OPM to verify an individual's self-certification of eligibility for the Extra Help with Medicare Prescription Drug Plan Costs program.

Finally, pursuant to section 716 of title 31, United States Code, GAO has authority to obtain the full file for investigative purposes. We provide the file to GAO upon request and without reimbursement.

[3] Although our agreement with DoD, MDC allows it to receive the full file annually plus monthly updates, its systems are not yet ready to receive the annual full file.

9) Explain how SSA distributes the full Death Master File to beneficiary paying agencies. Does SSA create a new Death Master File from the Numident for each agency, every time that agency updates its file?

We distribute the full DMF on a weekly, monthly, or annual basis based upon the agreements we have with each agency. When we create the weekly file, for example, we create one file and send it separately, via secure electronic connection, to the agencies that have opted to receive the weekly files. We follow the same process for the monthly and annual files. All agencies receiving the weekly file receive it on the same day. All agencies receiving the monthly file receive it on the same day. Agencies that receive the annual file generally receive it in June of each year.

The data for the annual file is an extract of all death records on our NUMIDENT file. Data for the weekly and monthly files are created from the death records we have successfully processed and posted to our NUMIDENT during the week or month prior to the creation of the file for that agency.

10) How much did SSA spend creating the full Death Master File for beneficiary agencies for each of the last three fiscal years?

We estimate that our total cost to create and distribute the full DMF to all six Federal benefit-paying agencies in FY 2012 would have been $273,302. The following information explains how we derived that figure and why it can only be an estimate.

We provide the full DMF to six Federal benefit-paying agencies. Four of these agencies—DoD, MDC; IRS; RRB; and HHS, CMS—reimburse us. Our total reimbursable costs for those agencies for the last three fiscal years were:

FY 2010 - $28,800
FY 2011 - $31,917
FY 2012 - $123,800

Our reimbursable costs increased significantly in FY 2012 because two agencies renegotiated their agreements with us to receive more data. We began sending IRS the full file, rather than the smaller, publicly available file, and we began sending CMS weekly, rather than monthly, updates of the full file.

As noted in our response to your question 8, we also provide the full DMF at no cost to two other Federal benefit-paying agencies—VA and OPM. As required by statute, we do not charge VA, and we provide the file to OPM as part of a reciprocal data exchange agreement.[4] VA and OPM do not reimburse us; therefore, we generally have no business reason to track our costs to create and distribute the file to them. However, they received the full file on the same schedule as the IRS in FY 2012, and our costs to create,

[4] The programmatic costs to us and OPM for these matches are borne by each agency and are offset by the value to each agency of the data exchanged; therefore, the expenses involved in providing the DMF to OPM is deemed to be paid for by the data provided by OPM to us.

verify, and transmit the data to each agency would probably have been the same. For purposes of this response, we can assume that we would have spent the same amount ($149,502 total or $74,751 each) to provide death information to VA and OPM last fiscal year. Because VA and OPM were the only agencies to receive the full DMF on a weekly basis in FY 2010 and FY 2011, we have no comparable costs for those two agencies for those fiscal years.

From Senator Claire McCaskill

1) **According to your testimony, pursuant to your statutory authority you are required to seek reimbursement to cover the reasonable cost of providing the full Death Master File (DMF) to other beneficiary agencies. According to the GAO, the Defense Manpower Data Center pays over $40,000 annually for monthly updates of the (DMF). I do not understand why it is reasonable for SSA to charge $40,000 to pull a list from existing data twelve times per year.**

Will you please provide to me a detailed explanation as to the types of costs for which you are seeking reimbursement from the Defense Manpower Data Center? For each type of reimbursement identified please cite the actual cost associated with the reimbursement. Please also include with this information on cost the number of staff assigned to operate the sharing of the data.[2]

For reimbursable activity, we follow the Office of Management and Budget Circular A-25, *User Charge*. In accordance with Circular A-25, our charges must be sufficient to cover the full cost to us for providing the services, resources, or goods as defined by the Federal Accounting Standards Advisory Board. Full costs include all direct and indirect costs of providing the data and are determined during the term of the agreement. Estimates are determined before the term of an agreement and may be higher or lower than actual costs.

We charged the DoD, MDC $8,225 in FY 2012 for the actual costs, not $43,000 as we originally estimated.[5] Below is a list of costs by type that we charged the DoD, MDC for FY 2012:

Type	Costs
Salaries[6]	$ 3,586
Office Overhead	$ 1,748
Agency Overhead	$ 1,864
Information Technology (IT) Costs	$ 562
IT Special Projects Charge	$ 465
Total	$ 8,225

For more information on what each type of cost represents, please see Enclosure 3, Explanation of Reimbursable Costs.

[5] Our original estimate for FY 2012 assumed that DoD, MDC systems would be able to start receiving the full file annually; however, DoD, MDC was not yet ready to start receiving the full annual file so we did not send it and did not charge for it.

[6] While this agreement, like all agreements, involves a number of employees from various staffs throughout the agency, the total number of hours used by these employees equals less than one full time employee.

2) **Your testimony indicated that the DMF data is tailored to each agency. Does this tailoring only refer to the frequency of updates, or do different agencies receive different types or differently modified data?**

The data contained in the file varies only as far as the weekly and monthly files contain all of the added, deleted, and changed records created during the previous week or month respectively, while the annual file contains all of the death records that are present on our NUMIDENT. All agencies who receive the weekly file receive the same data; all agencies who receive the monthly file receive the same data; and all agencies who receive the annual file receive the same data.

IMPORTANT NOTICE FOR FEDERAL AGENCIES – CHANGE IN PUBLIC DEATH MASTER FILE RECORDS

We receive Death Master File (DMF) data from the Social Security Administration (SSA). SSA receives death reports from various sources, including family members, funeral homes, hospitals, and financial institutions.

Q: What change is SSA making to the Public DMF?

A: Effective November 1, 2011, the DMF data that we receive from SSA will no longer contain protected State death data. Section 205(r) of the Social Security Act prohibits SSA from disclosing State death records SSA receives through its contracts with the States, except in limited circumstances. (Section 205r link - http://www.ssa.gov/OP_Home/ssact/title02/0205.htm)

Q: How will this change affect the size of the Public DMF?

A: The historical Public DMF contains 89 million records. SSA will remove approximately 4.2 million records from this file and add about 1 million fewer records annually.

Q: Is my agency eligible to receive State death data under section 205(r) of the Act directly from SSA because my agency pays federally funded benefits?

A: SSA is required to disclose State death data to Federal agencies to ensure proper payment of "federally funded benefits" under section 205(r)(3) of the Act. If your agency administers income maintenance or health maintenance programs that are federally funded, your agency may be eligible to receive the State death data from SSA. If you believe your agency qualifies for State death data, SSA will accept requests by e-mail at ogc.opd.controls@ssa.gov. Your request should contain a detailed explanation of the "federally funded benefit" program that your agency administers.

REMINDER: DMF users should always investigate and verify the death listed before taking any adverse action against any individual.

Source for Enclosure 2: SSA, November 2011

Explanation of Reimbursable Costs

Salaries

The salary costs include pay for the time employees directly perform the reimbursable work. This cost does not include personnel benefits or cover salaries of employees not directly involved with the reimbursable work. The cost does not include time consumed in short-term, non-extensive preliminary discussions, nor does it include supervisory and support time accounted for in the component's overhead.

Office Overhead

The office overhead costs include the indirect costs incurred by the agency components that perform the reimbursable work. The costs listed below help support the staff directly involved with the work and include:

- Salaries of supervisors, secretaries, administrative assistants, and other staff who are indirectly involved in performing the reimbursable work;
- Direct and indirect personnel benefit costs, including earned leave and training costs;
- Administrative supplies, materials, printing, reproduction, travel; and
- Any other indirect costs not named above that would be applicable.

Agency Overhead

Agency overhead includes the costs of providing administrative support for the reimbursable work performed. These costs include work performed by components that are not directly involved with performing the reimbursable activity, but provide support services. Examples of support services include reviewing the agreements to ensure compliance with law and providing financial services such as billing and collecting. This overhead also covers agency costs such as rent, utilities, etc.

Information Technology (IT) Systems Costs

IT systems costs include any direct IT costs associated with the reimbursable job, which primarily consist of central processing unit time and any information technology costs associated with providing the data.

IT Special Projects Charge

IT special projects charge is a small fee to help cover costs directly associated with systems improvements for reimbursable workloads.

Post-Hearing Questions for the Record
Submitted to Ms. Nancy Berryhill (SSA)
From Chairman Bill Nelson and Ranking Member Susan M. Collins

"Social Security Administration: Reduction in Face-to-Face Services"
June 18, 2014

NELSON

1. The Committee understands that Service Area Reviews (SARs) and Service Delivery Assessments (SDAs) document SSA's decision to close an office. With that in mind, for offices closed in 2013 and 2014, please cite parts of relevant SARs or SDAs that support the following statements Ms. Berryhill made during her testimony:
   (a) In closing the Quincy office, SSA considered the lack of public transportation between Quincy and Tallahassee.
   (b) In closing offices, SSA looked at Internet access.
   (c) In closing offices, SSA considered the closure's impact on the public and stakeholders.
2. Ms. Berryhill said SSA shares space with a county office in Northern Michigan. If SSA can share space, why was Gadsden County's offer of office space not considered?
3. SSA's May 2014 report to Congress says the Deputy Commissioner for Operations presents recommendations for closure to the Commissioner, who approves the decisions.
   (a) In her testimony Ms. Berryhill said, "These decisions are made by me," in reference to office closures. Given the contradiction, who makes the decision? If Commissioner Colvin is the final decision maker, have there been instances when Ms. Berryhill has made a recommendation that Commissioner Colvin has disagreed with? Please cite any instances.
   (b) Of the 25 documents SSA sent the Committee, only two were accompanied by recommendations to close an office. Please explain why the 23 other office closures did not have recommendations specifying the rationale for the closure.
4. The Committee asked SSA to consider five recommendations for improving its office-closure policy and practices. Please either agree or disagree with each recommendation. For those recommendations with which you agree please outline actionable steps you will take and a timeline for taking those steps. For those recommendations with which you disagree provide a rationale.
5. Please provide all the remaining documents justifying all office closures since 2010.

COLLINS

1. The Federal Management Regulation (§102-79.55) states that federal agencies must follow a hierarchy in their use of space. Federal agencies must: (a) first use space in Government-owned and Government-leased buildings; and (b) if there is no suitable space in Government-owned and Government-leased buildings, use space in buildings under the custody and control of the U.S. Postal Service; and (c) if there is no suitable space in

buildings under the custody and control of the U.S. Postal Service, agencies may acquire real estate by lease, purchase, or construction.

In your testimony, you discussed SSA's commitment—now and in the future—to sustain a field office structure that provides face-to-face service for those customers who need or prefer such service. You also talked about how budget constraints have led SSA to review service delivery options, which resulted in the elimination of contact stations and consolidation of some field offices.

a. Has SSA considered co-locating field offices with other agencies that are in Government-owned or Government-leased buildings or with the U.S. Postal Service?

b. In instances where SSA has consolidated a field office, was consideration given to co-locating with another agency in the same area? What determination was made in these instances?

c. As part of SSAs ongoing review of the field office structure, will co-location options be considered and documented in the Service Area Review assessments?

Congress of the United States
House of Representatives
COMMITTEE ON WAYS AND MEANS
WASHINGTON, DC 20515

SUBCOMMITTEE ON SOCIAL SECURITY

July 17, 2013

David A. Weaver
Associate Commissioner
Office of Program Development and Research
Social Security Administration
6401 Security Boulevard
Woodlawn, MD 21207

Dear Mr. Weaver:

Thank you for your and Mr. Williams's testimony before the Committee on Ways and Means Subcommittee on Social Security at the June 19, 2013 hearing on "Encouraging Work Through the Social Security Disability Insurance Program." In order to complete our hearing record, we would appreciate your response to the following questions:

1. The President's Fiscal Year (FY) 2013 budget included a proposal to simplify the work rules to help beneficiaries return to work, known as the Work Incentives Simplification Pilot (WISP). However, the President's FY 2014 budget did not include WISP but included a request for broader authority to test early interventions. Does the Administration still support WISP?

2. On page four of your testimony you state that under the Vocational Rehabilitation (VR) Cost Reimbursement Program, in FY 2012, the Social Security Administration (SSA) made over 5,300 payments to VR agencies totaling almost $79 million based on the work activity of over 4,400 beneficiaries. On average, what percent of individuals who have received these VR services leave the rolls and for how long? Would you consider this program a success?

3. Under current law, individuals working above the substantial gainful activity threshold are no longer be eligible for benefits after 12 months once the Trial Work Period is completed and the grace period ends. Have you examined the impacts of providing cost reimbursement to VR after individuals leave the rolls instead of before?

4. On page three of your testimony is a flow chart entitled "The Complexity of Returning to Work" illustrating the maze of work incentives a beneficiary trying to return to work must navigate. You noted in your testimony that the budget does not track the cost of these work incentives. Why is that? Do beneficiaries typically use just one work incentive or are several used in combination, and what percentage of eligible beneficiaries actually use these work incentives? Further, how much has been spent on the Ticket to Work (Ticket) program to date, and how many beneficiaries have left the rolls as a result? What is the savings of the Ticket program?

Additionally, please answer the following questions from Congressman Aaron Schock:

5. Based on available data regarding the number of DI applicants and beneficiaries who have earnings, how many of these individuals do you estimate could return to work or increase their earnings with assistance in transitioning back to work?

6. The SSA works with VR and employment network providers to encourage people to return to work. It also works with third-party representatives who screen out some claimants who don't qualify and help those who do qualify move along the process. Has the SSA studied ways in which these groups can get involved in improving the Ticket Program? Has any consideration been given to moving the Ticket program to a step earlier in the process (ex. tying Ticket with the DI application review process)?

We would appreciate your responses to these questions by ***July 31, 2013***. Please send your response to the attention of Kim Hildred, Staff Director, Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, B-317 Rayburn House Office Building, Washington, DC 20515. In addition to a hard copy, please submit an electronic copy of your response in Microsoft Word format to jessica.cameron@mail.house.gov.

Thank you for taking the time to answer these questions for the record. If you have any questions concerning this request, you may reach Kim at (202) 225-9263.

Sincerely,

SAM JOHNSON
Chairman

SOCIAL SECURITY

Office of Retirement and Disability Policy

DEC 9 2013

The Honorable Sam Johnson
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your July17, 2013 letter requesting additional information to complete the record for the hearing on work incentives in our disability programs. Enclosed you will find the answers to your questions and Representative Schock's questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

David Weaver
Associate Commissioner
for Program Development and Research

Enclosures (2)

Questions for the Record
For the June 19, 2013 Hearing
On Return to Work

Questions from Chairman Sam Johnson

1. **The President's Fiscal Year (FY) 2013 budget included a proposal to simplify the work rules to help beneficiaries return to work, known as the Work Incentives Simplification Pilot (WISP). However, the President's FY 2014 budget did not include WISP but included a request for broader authority to test broader interventions. Does the Administration still support WISP?**

   In addition to providing new authority to test early interventions, the President's FY 2014 budget proposes a reauthorization of existing disability insurance (DI) demonstration authority. Reauthorization would allow us to continue to test ways to boost employment and support return to work for current DI and Supplemental Security Income (SSI) beneficiaries, including exploring work incentive simplifications.

2. **On page of four of your testimony, you state that under the Vocational Rehabilitation (VR) Cost Reimbursement Program, in FY 2012, the Social Security Administration (SSA) made over 5,300 payments to VR agencies totaling almost $79 million based on the work activity of over 4,400 beneficiaries. On average, what percentage of beneficiaries who have received these services leave the rolls and for how long? Would you consider this program a success?**

   We recently reviewed data on the 3,420 disability beneficiaries who initially assigned their Tickets in 2006, and for whom we made a subsequent payment to a State VR agency under the traditional cost-reimbursement payment method. We found that over a 6-year period, 78 percent of these beneficiaries did not receive cash benefits because of work for at least 1 month, and 32 percent were not receiving benefits at the end of the period.

   Because the VR cost reimbursement program is a nationally available and voluntary program, it is difficult to assess the program's success in terms of its net effect on earnings or its cost effectiveness. Researchers have tried different methods to answer these questions using comparison groups drawn from individuals who are similar to participants, such as applicants who withdraw from VR before receiving services. These studies generally find positive returns to VR investment for client earnings (see, for example, Dean, *et al* 2001 [1]), but because there are likely to be relevant differences between those in the comparison group and those getting VR services, none of these methods has provided definitive answers (see Bloom *et al*, 2002[2] for a review of the results from comparison group impact methods as compared to experimental methods). A recent examination focusing on VR impacts for people

[1] Dean, D., Dolan, R., Schmidt, R., Wehman, P., Kregel J., and Revell, G. (2001). *A Paradigm for Evaluation of the Federal-State Vocational Rehabilitation Program*. Richmond, Virginia: Rehabilitation Research and Training Center for Workplace Supports, Virginia Commonwealth University.

[2] Bloom, Howard S., Charles Michalopoulos, Carolyn J. Hill, Ying Lei (2002). *Can Nonexperimental Comparison Group Methods Match the Findings from a Random Assignment Evaluation of Mandatory Welfare-to-Work Programs?* MDRC Working Papers on Research Methodology.

with mental illness (see Dean, *et al*, 2013[3]) found smaller, but positive, returns to VR investment for client earnings, but also found that VR increased the likelihood of receiving benefits.

3. **Under current law, individuals working above the substantial gainful activity threshold are no longer be eligible for benefits after 12 months once the Trial Work Period is completed and the grace period ends. Have you examined the impacts of providing cost reimbursement to VR after individuals leave the rolls instead of before?**

   No. We would need to establish a demonstration project to test the effect of the new VR payment structure on beneficiaries who leave the rolls due to earnings. We currently lack the statutory authority to test this change. As you know, the President's FY 2014 budget proposes a reauthorization of existing DI demonstration authority.

4. **On page three of your testimony is a flowchart entitled "The Complexity of Returning to Work" illustrating the maze of work incentives a beneficiary trying to work must navigate. You noted in your testimony that the budget does not track the cost of these work incentives. Why is that? Do beneficiaries typically use just one work incentive or are several used in combination, and what percentage of eligible beneficiaries actually use these incentives? Further, how much has been spent on the Ticket to Work (Ticket) program to date, and how many beneficiaries have left the rolls as a result? What is the savings of the Ticket program?**

   We have numerous work incentives, or employment supports, to assist beneficiaries in their efforts to become self-sufficient through work. Because our work incentives are interrelated and we consider all of our work incentives together when we make decisions about work activity in the DI program, we cannot track the cost of each work incentive separately.

   Since our work incentives are interrelated, the majority of beneficiaries who use work incentives will use more than one. For example, all DI beneficiaries who work at a level that ultimately results in suspension or termination of benefits will first complete the Trial Work Period and then enter the Extended Period of Eligibility, a period during which beneficiaries may receive payment for any month they do not perform substantial gainful activity. We know that work is often episodic for our beneficiaries, and many will need different work incentives at different times with different employers. Our beneficiaries have a wide range of impairments and represent diverse age groups, levels of education, work experience, and capacities for potentially returning to work. Therefore, our work incentives are a total package that provides multiple levels of support to beneficiaries attempting to achieve greater economic independence.

   Several of our evaluation reports have included information on awareness and use of SSA work incentives. Table 30 from the report "2006 National Beneficiary Survey: Methodology and Descriptive Statistics," http://socialsecurity.gov/disabilityresearch/documents/TTW5_4_NBSstats2.pdf, shows

[3] Dean, D., Pepper, J., Schmidt, R., and Stern, S. (2013). *The Effects of Vocational Rehabilitation for People with Mental Illness*. Working paper.

awareness and self-reported use of work incentives based on data from the 2006 National Beneficiary Survey (NBS). Exhibit 18 from the report "SSI and DI Beneficiaries with Work-Related Goals and Expectations," http://socialsecurity.gov/disabilityresearch/documents/TTW5_5_WOB.pdf, shows use of work incentives based on administrative data from the 2007 Ticket Research File, which tracks beneficiary demographics, work activity, and earnings. This table illustrates how use based on our administrative data differs from reported use from the survey data shown in Table 30. Finally, Table III.24 from the report "2010 National Beneficiary Survey: Methodology and Descriptive Statistics," http://socialsecurity.gov/disabilityresearch/documents/NBS%20stats%20methods%20508.pdf, provides updated figures on awareness of work incentives based on data from the 2010 NBS. We have not updated the self-reported use of work incentives figures based on the 2010 NBS data.

I have also enclosed two tables (see Enclosure 2), which provide more information on the numbers of beneficiaries who currently use work incentives. The first table comes from unpublished agency data and shows those who completed the Trial Work Period, entered the Extended Period of Eligibility and had their benefits suspended and finally terminated, and had subsidies or impairment related work expenses considered as part of the work determination. The second table is from our SSI annual statistical report, http://www.socialsecurity.gov/policy/docs/statcomps/ssi_asr/2012/ssi_asr12.pdf, and shows 2012 use of certain work incentives by SSI recipients.

Regarding the cost and savings of the Ticket program, the answers to these questions are more complex than a simple accounting of operational costs. The most current comprehensive estimate we can provide is for 2009 from Mathematica Policy Research, Inc.'s (Mathematica) evaluation report "Can the Ticket to Work Program Be Self-Financing?," http://www.socialsecurity.gov/disabilityresearch/documents/TTW%20Financing%20508.pdf. In FY 2009, Mathematica determined our operational costs and payments to employment networks were approximately $46 million.

We do not receive a specific appropriation for the Ticket program; we fund the program from our regular budget. As a result, our accounting system does not track operational costs for the Ticket program. Moreover, estimating operational costs requires interviewing agency employees who implement the program, collecting agency administrative information, and making assumptions about the magnitude of Ticket program activities relative to all our activities related to beneficiary work efforts. Ticket program costs have increased since 2009 due to changes to the structure of our Program Manager contracts. Much of the increases are temporary, so it is currently unclear whether these changes will imply long-term annual costs for the Ticket program that are above the 2009 estimates.

To determine the effect of the program, we must consider the costs in relation to what would have occurred in the absence of the program. A recent evaluation by Mathematica, which focused on the period before 2008, concluded that the Ticket program produced no measurable effects on work activity or reductions in benefit payments due to work. Without measurable effects, we cannot state that there were savings from the Ticket program through 2007.

We do not think it will be possible to estimate effects for the period after 2007. However, outcomes after 2007 are the same or somewhat poorer than in the earlier period, so there is no reason to think that the effects have improved.

Questions from Representative Aaron Schock

5. **Based on available data regarding the number of DI applicants and beneficiaries who have earnings, how many of these individuals do you estimate could return to work or increase their earnings with assistance in transitioning back to work?**

Based on our research, we believe that most beneficiaries cannot return to the level of work necessary to no longer be eligible for DI benefits, but many beneficiaries are interested in working in some capacity. The "2010 National Beneficiary Survey: Methodology and Descriptive Statistics," http://socialsecurity.gov/disabilityresearch/documents/NBS%20stats%20methods%20508.pdf, provides the major findings from a survey of beneficiaries who were receiving DI or SSI disability benefits in 2010. From this survey, we have information on the characteristics of beneficiaries who work, those who are able to work, and those interested in work.

In the same 2010 survey, 91percent of all beneficiaries reported that their physical or mental condition prevents work. Roughly, 7 percent of all beneficiaries reported they were working when we interviewed them, and 5 percent were looking for work. In the previous year, 10 percent of all beneficiaries reported working. Sixteen percent of all beneficiaries interviewed and 22 percent of working beneficiaries saw themselves working and earning enough to leave benefits within 5 years.

Interest in work in some capacity is broader than just the beneficiaries who are working at the time of the interview. Of beneficiaries interviewed in 2010, 40 percent were interested in working at some point; they either expected to work in the future or had career goals and expectations. We refer to these individuals as work oriented and note that this proportion has remained relatively constant since we first measured it in 2004. From "SSI and DI Beneficiaries with Work-Related Goals and Expectations," http://www.socialsecurity.gov/policy/docs/ssb/v71n3/v71n3p61.html, we know that most work-oriented beneficiaries eventually engage in return-to-work activities.

Our 2010 survey also provides information on the services used by employed beneficiaries. In the prior year, employed beneficiaries used employment services for work assessment and help finding a job (54 percent), and a combination of other employment services, including job training, on-the-job training, job modification, and job advice (58 percent).

In addition to showing the attitudes and employment-related activities of work-oriented beneficiaries, the same 2010 survey illuminated some of the key characteristics of the 10 percent of beneficiaries who had been recently employed when we interviewed them. There are distinct differences between the 90 percent of beneficiaries who were not working and the 10 percent who were working. Compared to all beneficiaries, the employed beneficiaries:

- Experienced the onset of their disability at a younger age (49 percent of working beneficiaries had disability onset before age 18 versus 22 percent for all beneficiaries).
- Have no difficulties with Activities of Daily Living (ADL), such as bathing, dressing, or getting around inside the home. They also have no difficulty with Instrumental Activities of Daily Living (IADL), such as shopping or getting around outside of the home (48 percent of working beneficiaries have no ADL/IADL difficulties versus 28.2 percent for all beneficiaries).
- Are in better health, and their health has not declined (16 percent of working beneficiaries had poor or very poor health, and 6 percent had health that was worse than the previous year versus 42 percent with poor or very poor health and 17 percent with declining health among all beneficiaries).
- Are more likely to have a high school education (27 percent of working beneficiaries have not completed a high school degree or a GED versus 34.3 percent for all beneficiaries).

Among employed beneficiaries:

- Forty percent of all employed beneficiaries worked in supported employment/sheltered workshops.
- Fifty-nine percent of employers of all working beneficiaries made at least one accommodation.

The survey also identified the following supports or accommodations for working beneficiaries: help finding a better job, more flexible work schedules, reliable transportation, help caring for children or others, help with personal care, and special equipment.

While certain characteristics are associated with work, we cannot predict who and how many beneficiaries will return to work. Who will work depends on many individual and environmental factors that we either cannot measure well or cannot measure at all. We continue to pursue ways to access new sources of information that may help us assess this issue.

6. **The SSA works with VR and employment network providers to encourage people to return to work. It also works with third-party representatives who screen out some claimants who don't qualify and help those who do qualify move along the process. Has the SSA studied ways in which these groups can get involved in improving the Ticket program? Has any consideration been given to moving the Ticket program to a step earlier in the process (ex. tying Ticket with the DI application review process)?**

Third-party representatives do not screen out claimants for us. If a claimant hires an attorney or non-attorney representative to help with his or her claim, we may have contact with that third-party representative, but the representative works for the claimant, not SSA. We have not studied the role third-party representatives can play in our return to work efforts.

Currently, the law does not authorize us to provide vocational rehabilitation services to people who are not receiving DI or SSI benefits. While we have not studied the early interventions

you describe, we are interested in studying the effect of early intervention. We look forward to working with you on ways we might study the effects of using early intervention, provided we possess the necessary resources and demonstration authority. As you know, the President's FY 2014 budget proposes a reauthorization of existing DI demonstration authority.

Disabled Workers

Number utilizing work incentives and terminated due to substantial gainful activity (SGA) by year.

	Utilizing a Trial Work Period (TWP)		Completed a TWP		Suspended during the Extended Period of Eligibility		Utilizing the impairment related work expenses work incentive		Utilizing a Subsidy		Terminated due to SGA[a]	
Calendar Year	Number	Percent of total disabled beneficiaries (December)	Number	Percent of total disabled beneficiaries (December)	Number	Percent of total disabled beneficiaries (December)	Number	Percent of total disabled beneficiaries (December)	Number	Percent of total disabled beneficiaries (December)	Number	Percent of total disabled beneficiaries (December)
2008	235,739	3.2	96,718	1.3	139,448	1.9	11,000	0.1	23,500	0.3	37,711	0.5
2009	185,615	2.4	76,087	1.0	124,307	1.6	10,000	0.1	22,500	0.3	32,445	0.4
2010	185,825	2.3	68,863	0.8	111,578	1.4	9,500	0.1	20,500	0.2	40,959	0.5
2011[b]	176,609	2.1	73,018	0.9	102,068	1.2	9,000	0.1	18,000	0.2	39,813	0.5
2012[b]	113,388	1.3	46,739	0.5	76,320	0.9	6,500	0.1	12,000	0.1	38,228	0.4

a. Year when processed.
b. Work reviews are still incomplete for 2011 and 2012.

Recipients Who Work

Table 46.
Blind and disabled recipients who work and their average earnings, by selected characteristics, December 2012

Characteristic	Number	Percent	Average monthly earnings (dollars)
Total	313,634	100.0	526
Work incentives [a]			
Section 1619(a)	11,823	3.8	1,298
Section 1619(b)	67,920	21.7	1,318
Plan to achieve self-support (PASS)[b]	315	0.1	824
Impairment-related work expenses	3,157	1.0	670
Blind work expenses	1,410	0.4	1,090

NOTE: Includes section 1619(b) participants.
a. The sum of the entries may be greater than the total because some recipients may receive more than one type of earned or unearned income or both earned and unearned income, or they may benefit from more than one work incentive provision.
b. Number of working recipients with a PASS. See Tables 53–56 for data on all recipients with a PASS.

SOCIAL SECURITY

The Commissioner

November 14, 2013

The Honorable James Lankford
Chairman, Subcommittee on Energy Policy,
Health Care and Entitlements
Committee on Oversight and Government Reform
House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your July 9, 2013 letter to Deputy Commissioner Glenn Sklar requesting additional information to complete the record for the hearing on administrative law judges. Due to the comprehensive nature of your inquiry, I am responding to your letter. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

Carolyn W. Colvin

Carolyn W. Colvin
Acting Commissioner

Enclosure

Questions for the Record
For the June 27, 2013 Hearing
On Administrative Law Judges
Questions from Chairman Lankford

1. **Does the Social Security Administration recognize any problems related to growth in the number of people enrolled in Social Security Disability Insurance (SSDI) and Supplemental Security insurance (SSI) over the past decade? If so, please explain.**

   The SSDI and SSI programs provide critical income for people who are unable to work due to a severe disability and need this help. While we anticipated an increase in claims due to the aging of the baby boom, we could not anticipate the economic recession or the constraint on funding appropriations for administering the program in recent years. Therefore, from an administrative standpoint, our primary challenge is properly adjudicating this increase in claims with limited resources.

2. **Does the Social Security Administration have any concerns about the rise of subjective categories of disabilities, such as depression or pain, over the past few years? If so, please explain. Please also explain any actions SSA has taken because of the rise in subjective categories of disability. Does SSA attribute any of the rise in growth in the number of people enrolled in SSDI to the rise of subjective disability categories?**

   Our rules prohibit us from finding claimants disabled based solely on subjective statements about pain or other symptoms. To find claimants disabled, we must have objective medical evidence supporting those decisions. We require objective medical evidence and laboratory findings, established by medically acceptable clinical or laboratory techniques. The evidence must show the existence of a medical impairment resulting from anatomical, physiological, or psychological abnormalities, which could reasonably be expected to produce the pain or other symptoms and which, when considered with all of the other evidence, leads us to conclude that the claimant is disabled. 20 CFR §§ 404.1529, 416.929. There are, however, subjective elements to evaluating medical conditions across almost all medical listings. For example, we evaluate pain under the cardiovascular system, musculoskeletal system, neurological, immune system disorders, and mental disorders body systems, among others.

   Much of the increase in the number of claims based on musculoskeletal and mental impairments is due to more people applying for benefits under our programs. Many factors account for the increase in claims, including raising the full retirement age, growth in the number of women in the labor force, aging of the baby boom generation, and the economic downturn. When more workers of advanced age apply, we can expect an increase in the number of allowances, particularly in the musculoskeletal body system.

   As a percentage of all claims, we have not seen an increase in claims we have allowed due to musculoskeletal and mental impairments. The 5-year trend from fiscal year (FY) 2008 to FY 2012 indicates consistent initial allowance rates for the musculoskeletal body system. In the mental body system area, the overall allowance rate, including for impairments such as depression, has actually decreased in the past few years. The FY 2012 allowance rate for

claims based on a mental impairment is 10 percentage points lower than in FY 2008. The number of initial claims that we allowed based on a mental impairment peaked in FY 2010 (376,933) and was at the lowest number over the past five years in FY 2012 (318,878).

As we update the medical listings, we provide specific descriptive criteria for functional limitations, thus shifting our focus from a claimant's description of his or her activities to the abilities that the claimant needs to perform gainful activity. This shift in focus will help us more objectively evaluate symptoms such as pain under our medical listings where they are more commonly present, such as the cardiovascular, musculoskeletal, neurological, immune system, and mental disorders body systems.

To help our adjudicators properly apply our complex policies on evaluating evidence while also handling increasing workloads, we have emphasized internal training. We are always monitoring trends in allowance rates to see if additional training or policy revisions are appropriate.

3. **Is it appropriate for doctors to consider non-medical factors such as the patient's level of education and local economic conditions when evaluating a patient for disability?**

No. Our rules make it clear that the role of a doctor is to: 1) evaluate the medical factors (i.e., signs, symptoms, and laboratory findings); and 2) make a medical judgment as to whether the medical evidence establishes that the claimant has a medically determinable impairment or impairments (impairment), the nature of the impairment, and the effect of the impairment on the claimant's functioning. These medical findings include the functions or activities the claimant cannot or should not do because of his or her impairment.

4. **What guidance or instruction has Social Security Administration provided to doctors about considering factors such as the patient's level of education and local economic conditions when evaluating a patient for disability?**

We rely on doctors for their medical expertise. The doctor's role in the disability determination process is to provide medical evidence to disability decision-makers. Education is a vocational consideration and not a medical consideration under our rules. Moreover, our regulations specifically prohibit considering the local economic climate as a factor in disability determinations. 20 CFR §§ 404.1566(c), 416.966(c). We publish various materials that convey our expectations for doctors. For example, we publish a booklet, *Answers for Doctors & Other Health Professionals*, which can be found at http://socialsecurity.gov/disability/professionals/answers-pub042.htm. This explains what information should be included in the medical report.

5. **Is the Social Security Administration able to update the grid immediately so that the inability to speak English is not a factor in disability determinations in Puerto Rico?**

No. The grids reflect longstanding policy that we incorporated into our regulations. If we determined that a policy revision would be warranted, we would need to follow the notice-and-comment rulemaking procedures in the Administrative Procedure Act before we could revise our grid rules. I would also note that we allow very few claims based on a

beneficiary's inability to speak English. In fiscal year 2012, we allowed 83 cases on this basis in Puerto Rico; these allowances comprised only one-half of 1 percent of all allowances in Puerto Rico.

6. **When did the Social Security Administration make the decision to divert resources away from medical CDRs to processing initial claims? Why?**

We do not divert resources from medical continuing disability reviews (CDR) to process initial claims. We continue to fully and effectively use the program integrity funding provided by Congress for medical CDRs.

7. **Does SSA have a plan to deal with the significant backlog of medical CDRs? What is the plan?**

Yes. The FY 2014 President's Budget request included a legislative proposal aimed at assisting our efforts to increase the amount of cost-effective program integrity work completed each year. Under the Program Integrity Administrative Expense (PIAE) proposal, the funding level would allow us to work toward a goal of processing 1.047 million medical CDRs, which is over 600,000 more than we are completing this fiscal year. In order to complete that number of medical CDRs, we must receive funding at the start of the fiscal year, which would require congressional action. Even with funding at the beginning of the fiscal year, reaching our goal of 1.047 million CDRs in FY 2014 is ambitious. To reach that goal would require us to have additional fully trained staff in both our field offices and the State disability determination services (DDS) at the beginning of the fiscal year, which we have been unable to accomplish under our FY 2013 funding level.

If we are unable to achieve our goal in FY 2014, we would continue our progress in reducing the CDR backlog by using the two-year funding flexibility in the PIAE.

We had planned to use the Budget Control Act (BCA) level of dedicated program integrity funding to reduce our backlog of medical CDRs. However, Congress has not appropriated the authorized level of BCA funding for the past two years. We estimate we could complete 764,000 CDRs in FY2014 with an appropriation that is consistent with the BCA funding level.

When Congress provides adequate and dedicated funding for this workload, we deliver results. To address a previous CDR backlog, the *Contract with America Advancement Act of 1996* provided increased and dedicated funding for CDRs for fiscal years 1996 through 2002. Thanks to this funding, we eliminated the CDR backlog by the end of FY 2002.

8. Can you commit to ensuring that ALJs have the necessary income detection tools-such as bank records and credit reports—available to them so they can make more accurate determinations without relying on tax data that may not be current or complete? If so, please explain.

No. Disability examiners and other decision-makers, including administrative law judges (ALJ), do not need to use resource detection tools such as bank records and credit reports in making disability determinations and decisions. Our field office employees are responsible for evaluating income and resources.

9. Over the past decade and by year, how many complaints has SSA received from ALJs about attorney or non-attorney claimant representative misconduct? Over the past decade and by year, how many of those complaints have been reported to an appropriate state bar? Over the past decade and by year, how many attorneys or non-attorney claimant representatives has SSA banned from participating in SSA hearings?

We do not track the total number of complaints we receive from ALJs about attorney or non-attorney claimants' representatives. We also do not track the number of complaints made by ALJs about representatives that we ultimately refer to a State bar.

Since 2003, we have disqualified 108 claimants' representatives, as illustrated in the chart below. Our regulations permit disqualified representatives to seek reinstatement, and we may have reinstated some of these representatives since their disqualification.

Year	Number of Claimants' Representatives Disqualified
2003	5
2004	3
2005	6
2006	7
2007	21
2008	4
2009	7
2010	16
2011	14
2012	12
2013	13

10. In a November 2011 Wall Street Journal article, "Doctor Revolt Shakes Disability Program," several doctors said that supervisors told them that certain ailments should be considered 'severe,' even if the doctors disagreed. The article also states that "some doctors have complained to the SSA inspector general that they have been pressured to change their medical opinions to conform to targets or goals set by SSA officials, and they feared they would be fired if they resisted." Did SSA investigate whether doctors were pressured change medical opinions? What did SSA find? Did SSA take any disciplinary steps with regard to this matter? If so, please explain.

The allegations that doctors at SSA headquarters were "pressured to change their medical opinions to conform to targets or goals set by agency officials and that they feared they would be fired if they resisted" were made by some Medical Consultant Contractors (MCCs) in our Office of Medical and Vocational Expertise (OMVE). We reviewed the business process in OMVE, and concluded that the allegations were unfounded; the feedback given to the MCCs was to ensure that all medical reviews were compliant with our disability policy.

11. According to the same 2011 Wall Street Journal article, "Doctor Revolt Shakes Disability Program," the agency changed the way doctors are compensated from an hourly rate to a rate per case. Which doctors did this pay structure apply to? Who decided to change the pay structure? Why was the pay structure changed?

The pay-per-case model applies to all Federal MCCs in OMVE and in all of our regional offices that use MCCs. It was an agency, not individual, decision to adopt this model. We began to use a pay-per-case model in the Atlanta Region in about 2003. In 2006, we changed to pay-per-case model in the New York Region. We were impressed with the resulting increases in the MCC's efficiency and in 2010, implemented the pay-per-case model nationwide. The Baltimore MCCs referenced in the *Wall Street Journal* article were among the last to transition to the pay-per-case model. We have paid our Medical Experts, who provide medical advice to ALJs, by the case for many years.

We decided to change the pay structure for MCCs because the pay-per-hour structure was not motivating the doctors to be as efficient as possible when reviewing cases. Under a pay-per-hour system (labor-hour contracts), the doctors could review cases at their own pace, and there was no reward for working faster. Some doctors reviewed 1 or 2 cases per day, and they received the same compensation as doctors who reviewed 10 cases per day.

12. According to the Wall Street Journal article, "Doctor Revolt Shakes Disability Program," the SSA "planned to make certain changes" in response to the inspector general investigation of Alabama disability determination office doctors in February 2010. What changes have been made?

Based on our Office of the Inspector General recommendations, the Alabama DDS enhanced their Medical Consultant review process. Specifically, the Alabama DDS: 1) provided training on the review and signature process; 2) increased the number of doctors participating in the review and signature process rotation; and 3) increased the sample number of cases in their quality check business process.

13. Does SSA currently have production targets or goals for SSA medical consultants who review claims or contract directly with SSA? If so, what are these targets or goals?

We do not have production targets or goals for MCCs who review disability claims. The MCCs inform the agency of their availability and capacity to provide medical reviews for disability claims, and we purchase medical reviews as needed.

14. The Wall Street Journal article mentions that in November of 2011, SSA called a meeting with 140 doctors and changed protocols so that doctors could stray from their area of expertise when taking a case. When did this meeting take place, which SSA employees attended the meeting, and what was the agenda? Did SSA change its protocols so doctors could review cases outside their field of specialty? If yes, please provide rationale for allowing/encouraging doctors to review cases outside their respective specialty. Why or why not?

From February 2011 to May 2011 OMVE staff, including Program Analysts, Senior Case Reviewers, and Contracting Officers, held more than 53 orientation sessions for MCCs to reorient the MCCs to the "generalist" approach for reviewing disability claims. To accommodate schedules, we held multiple sessions on individual body systems. Our MCC specialists participated in the sessions along with OMVE staff so that we could provide medical and policy information. MCCs who provided information during the sessions were able to attend other sessions. We also held six general sessions on the "generalist" approach. We explained during the sessions that although we were initiating a "generalist" approach, MCCs could obtain a medical specialty consultation if necessary.

To support the transition to a pay-per-case business process, OMVE shifted to a generalist medical review model, when appropriate, instead of an exclusive specialist approach. Under the generalist model, the MCC reviewing a case assumes overall responsibility for completing the medical portion of the review, which is consistent with the practices used by our 10 regional Centers for Disability and virtually all State DDSs. This shift was both fiscally responsible and fully compliant with our disability policy. The generalist model puts MCCs in a better position to consider whether multiple health issues in a single case meet the disability criteria. Additionally, medical consultants working in the generalist model can request assistance from OMVE's pool of MCC specialists to address highly technical medical issues that require particular medical expertise.

15. b6 awarded benefits in roughly 2,000 cases per year.

b6 disposed of 2,102 cases in FY 2010, 1,216 cases in FY 2011, 1,062 cases in FY 2012, and 774 cases in FY 2013 through the end of June 2013.

Which individuals at SSA made the decision to transfer cases to b6 ? Have you held anyone accountable for transferring cases to b6 . Do you plan to hold anyone accountable?

In an effort to balance work nationally, the agency will at times transfer cases from offices that are unable to keep up with incoming hearing requests. This management practice

attempts to make the best use of limited agency resources and minimize the amount of time a claimant waits for a hearing decision. In February 2008, the Service Area Realignment Plan (Plan) formalized this long-standing practice. Under the Plan, we transferred workloads from regions with high receipts and high pending case levels (e.g., Chicago and Kansas City) to regions with lower receipts and lower pending case levels (e.g., Boston, Philadelphia, and San Francisco). Our Office of the Chief ALJ has continued to monitor national workloads and transfer cases accordingly.

To ensure quality decision-making and to protect the integrity of the hearing process, in July 2011, we instituted a cap on the number of cases ALJs are issued in a year. Initially, we set the cap at no more than 1,200 cases per year, and in November 2012, we reduced that number to 960 cases per year, or 80 cases per month. Prior to July 2011, once an office received transferred cases, they were assigned to ALJs as their workload permitted.

Do you believe that SSA should prioritize CDRs for individuals awarded benefits by b6 ?

We do not believe medical CDRs should be performed for claimants who were awarded benefits just because a particular ALJ made the decision. An ALJ disposing of a certain number of cases does not warrant us conducting medical CDRs for all the claimants who received favorable decisions from that ALJ absent a finding of fraudulent activity.

16. **b6 decided over 1,300 cases in 2010 and 1,003 cases in 2011.**

b6 disposed of 1,411 cases in FY 2010 and 1,030 cases in FY 2011. He retired on July 13, 2011.

Which individuals at SSA made the decision to transfer cases to b6 ? Have you held anyone accountable for transferring cases to b6 ? Do you plan to hold anyone accountable? Do you believe that SSA should prioritize CDRs for individuals awarded benefits by b6 ?

Please see our answer to question 15.

17. **During the years that b6 in Oklahoma City was deciding 2,000 cases per year and approving in excess of 90% of cases, he was reprimanded several times for producing poor quality, boilerplate decisions.**

b6 disposed of 1,343 cases in FY 2010, 1,164 cases in FY 2011, 559 cases in FY 2012, and 121 cases in FY 2013. He retired on January 3, 2013.

Which individuals at SSA made the decision to ship hundreds of cases from all over the U.S. to b6 even though he had been reprimanded several times for producing poor quality decisions & was already deciding a high number of cases per year? Have you held anyone accountable for transferring all of these cases to Judge O'Bryan over the years? Do you plan to hold anyone accountable? Do you believe that SSA should prioritize CDRs for individuals awarded benefits by b6 ?

Please see our answer to question 15.

18. When did the Social Security Administration begin making productivity goals for regional and local offices?

Disposition goals for the hearing operation have existed in some form since at least 1981. Disposition goals for the regional and hearing offices are driven by the Congressional budget process and are different from the agency's 500-700 disposition expectation for individual ALJs.

19. How did SSA use regional production levels as a way to evaluate regional office performances after 2006? What methods were used by SSA to encourage and/or enforce regional production goal?

The Office of Disability Adjudication and Review (ODAR) considers disposition numbers as one of many factors when assessing the performance of its hearing operation. Other factors include the average processing time of cases, the number of cases pending, the number of receipts, remands, and the time cases spend in the various stages of the hearing process. ODAR does not compel or enforce a particular number of dispositions; rather, ODAR expects that each aspect of the hearing operation will work at its fullest potential to try to achieve the articulated goals. ODAR assists the performance of the hearing operation by monitoring workload indicators and providing resources, including staff, training, and technological improvements.

20. How did SSA use local production levels as a way to evaluate local office performances after 2006? What methods were used by SSA to encourage and/or enforce local production goals?

Please see our answer to question 19.

21. Were regional or local offices rewarded for meeting productivity goals? Were regional offices or local offices punished for failing to meet productivity goals?

ODAR has not given any regional or hearing office an award solely based on meeting a disposition goal. ODAR has never punished a regional or hearing office for failing to meet a disposition goal.

22. Responding to a question from Chairman Lankford, you mentioned "states are actually giving out finder's fees to bring people to us." Please identify all the states that are giving out finder's fees. How are these finder's fees impacting the disability determination process?

The following National Public Radio article discusses the finder's fees that Mr. Sklar mentioned during the hearing: http://www.npr.org/2013/03/27/175502085/moving-people-from-welfare-to-disability-rolls-is-a-profitable-full-time-job.

We do not have any specific data on this issue.

23. Responding to a question from Chairman Lankford, you mentioned "what we don't want to do is clog up the rolls with folks who shouldn't be going through the system." What steps is SSA taking to ensure that state DDS is properly filtering out the "folks who shouldn't be going through the system" during the initial determinations?

The Social Security Act establishes criteria for receiving benefits, but it does not establish criteria for applying for those benefits. Therefore, if a person applies for disability benefits, we must process that application.

24. What is SSA's policy regarding the use of continuances to postpone hearings?

Our regulations permit an ALJ to stop a hearing temporarily and continue it later if he or she believes that there is material evidence missing at the hearing. 20 CFR §§ 404.944, 416.1444. However, continuing hearings generally delays issuing the decision. Therefore, an ALJ should continue a hearing only if there is a good reason to do so.

A continuance or supplemental hearing is appropriate when:

- certain testimony or a document presented at the hearing has taken the claimant by surprise, is adverse to the claimant's interest, and presents evidence that the claimant could not reasonably have anticipated, and to which the claimant is not prepared to respond;
- the ALJ believes additional testimony regarding a new issue is appropriate;
- the ALJ discovers during the hearing that the testimony of a person, who is absent, is needed, and the person may be available at a later date;
- the claimant or the ALJ wishes to present evidence but cannot present it by document, affidavit, or deposition without diminishing its probative value because of the absence of opportunity for detailed examination or cross-examination of the witness;
- an order of remand directs the ALJ to hold a supplemental hearing; or
- a request is made to cross-examine the author or provider of post-hearing evidence.

25. Does SSA discourage the use of continuances in the event a claimant arrives at the hearing with new medical evidence which the judge has not previously reviewed?

The mere presentation of additional evidence by the claimant at the hearing is not a sufficient reason to issue a continuance. However, as explained in the answer to question 24, if the additional evidence requires further testimony that cannot be heard on the original hearing date, the ALJ may conduct a supplemental hearing. Additionally, the ALJ may stop a hearing temporarily and continue it at a later date if he or she believes that there is material evidence missing at the hearing. 20 CFR §§ 404.944, 416.1444.

26. Please identify which evidentiary regulations the agency plans to "fix," and describe what steps have been taken (or what action will be taken). Please provide an expected timetable for SSA action in this area.

Our current regulations describe a disability claimant's duty to submit evidence in several ways. Based on our program experience, we know that some claimants and their

representatives submit only evidence that supports their disability claims. We recently consulted with the Administrative Conference of the United States (ACUS) to obtain its recommendations on how we could better articulate the duty to submit all relevant evidence in disability claims. ACUS issued its final report on October 15, 2012. Based in part on the recommendations and principles in ACUS' report, we are drafting proposed changes to the appropriate regulations to provide more clarity about the duty to submit all evidence that relates to disability claims. We are unable to provide a timetable at this time.

27. **How (specifically) are each of the Department of Labor, the Bureau of Labor Statistics, and the Disability Research Consortium involved in the process of updating the grid? Please provide an expected timetable for action in this area.**

The Disability Research Consortium has asked grantee Mathematica Policy Research to develop a proposal to conduct an evaluation of existing literature, reports, and studies to identify research on the effect of age, education, and prior work experience on a person's ability to adjust to doing work not previously performed. After review of the final proposal and budget, we anticipate an award to Mathematica by mid-November and expect the final deliverable by July 2014. This literature research is just the first step of our plan to review and update the vocational grid as needed.

We are working with the Bureau of Labor Statistics and the Department of Labor's Employment and Training Administration to produce an occupational information system to replace the Dictionary of Occupational Titles in our disability programs. However, we are not working with them to update the grid rules.

28. **Responding to a question from Chairman Lankford about SSA's timeline for updating the grid, you stated that the update would take "[p]robably closer to the six months, but maybe about two, three years for the full grid." What is SSA's timeline for updating the grid? When does SSA expect to have a draft proposal of the grid update? When does SSA expect to have a final version of the grid update? What is the current status of this project? Please submit SSA's current draft proposal to the Committee.**

We do not have a draft regulatory proposal at this time, as the necessary research has not been completed. A complete update of the grid rules would involve both consideration of updated information about the vocational factors (i.e., age, education, and past work experience) and updated information about the unskilled occupational base.

29. **Since FY 2000, SSA data show that the two most prevalent categories of mental impairments allowing children to draw SSI benefits have been ADHD and speech and language delays. In light of this, please provide the specific criteria used or prescribed by the Administration to approve SSI benefits for children diagnosed with ADHD and speech and language delays.** [1]

The SSI program makes monthly payments to children under age 18 who are disabled and have income resources below certain limits. We consider a child disabled under the SSI

[1] http://www.gao.gov/assets/600/591872.pdf

program if the child has an impairment that: 1) has lasted or can be expected to last for a continuous period of not less than 12 months or can be expected to cause death; and 2) causes "marked and severe" functional limitations. We use a three-step sequential evaluation process to determine disability:

Step 1 - We determine whether the child is working, and if so, whether the work is substantial gainful activity. If the child is performing substantial gainful work, we will determine that the child is not disabled without further review of his or her claim. If the child is not engaging in substantial gainful work, we continue to step 2.

Step 2 - We determine whether the child has an impairment that is severe. If the child does not have impairment or the impairment is a slight abnormality that causes no more than minimal functional limitations, we will determine that the child is not disabled. If the child is found to have a severe impairment, we continue to step 3.

Step 3 - We determine whether the child's impairment(s) meets, medically equals, or functionally equals the listings. An impairment causes "marked and severe" functional limitations if it meets or medically equals the severity of a set of criteria for an impairment in the listings, or if it functionally equals the listings. If the child's impairment does not meet, medically equal, or functionally equal the listings or does not meet the duration requirement, we determine that the child is not disabled. If the child has an impairment that meets or medically equals the requirements of a listing or that functionally equals the listings, and meets the duration requirement, we determine that the child is disabled.

In determining whether a child's impairment functionally equals the listings, we determine whether it results in "marked" limitation in two domains of functioning or "extreme" limitation in one domain. The domains that we use are:

- Acquiring and using information;
- Attending and completing tasks;
- Interacting and relating with others;
- Moving about and manipulating objects
- Caring for oneself; and
- Health and physical well-being.

The presence of a mental disorder, such as attention deficit hyperactivity disorder (ADHD), in a child must be established by medical evidence consisting of symptoms, signs, and laboratory findings from an acceptable medical source. We measure the severity of a child's mental disorder according to the functional limitations imposed by the disorder, and we consider all relevant evidence in the case record, including objective medical evidence. Descriptions of the child's functional limitations may be available from acceptable medical

sources, either in the form of standardized test results, in other medical findings supplied by the sources, or in both. We never use test scores alone to determine whether a child is disabled. We also use information from nonmedical sources to help us determine the severity of the child's impairment. These sources are people who have information about the child's daily functioning and include, for example, parents or caregivers, teachers, social workers, as well as occupational, physical, and speech/language therapists and others who are familiar with the child. When we evaluate a child's functioning, we compare his or her functioning to that of other children the same age who do not have impairments.

A child who has ADHD can have signs and symptoms of ADHD that interfere with a broad range of childhood activities. When we evaluate the limitations resulting from ADHD, we begin by considering the child's activities at home, at school, and in the community and determine whether he or she is limited in engaging in those activities. When we assess ADHD under medical listing 112.11, Attention Deficit Hyperactivity Disorder, we find the impairment is disabling when there are medically documented findings of marked inattention, marked impulsiveness, and marked hyperactivity and a designated number of paragraph B criteria under listing 112.02, Organic Mental Disorders, are satisfied.

When we assess ADHD under our functional equivalence rules, we identify the functional domains involved in performing each of the limited activities resulting from the child's impairment(s) and rate the severity of limitations. For example, a child with ADHD may have difficulty paying attention in the classroom, which we consider under the domain of "Attending and completing tasks." Because of poor impulse control, a child with ADHD may interrupt conversations inappropriately, which we consider under the domain of "Interacting and relating with others." When the child's impairment causes "marked" limitation in two domains or "extreme" limitation in one domain, we find the child disabled. A "marked" limitation represents a serious limitation of function; on standardized testing, it is two standard deviations below the mean. An "extreme" limitation represents a very serious limitation of function; on standardized testing, it is three standard deviations below the mean.

We consider speech and language impairments in children that result from any cause, whether they are congenital, developmental, or acquired. When we assess speech and language impairments under the medical listings, we use listing 2.09, Loss of speech, or listing 111.09, Communication impairment, associated with documented neurological disorder. We may also follow the guidelines in Social Security Ruling (SSR) 98-1p to determine whether a combination of cognitive and speech disorders medically equals the listings.

When we assess speech and language disorders under our functional equivalence rules, we identify the functional domains involved in performing each of the limited activities resulting from the child's impairment and rate the severity of limitations. We consider both test scores and evidence of daily functioning. We do not assign language or speech impairments to specific domains, but as with all other impairments, consider a child's communication activities in whichever domain(s) is involved in those activities. For example, when using language to learn and think, the child is acquiring and using information; when using

language to play with friends, the child is interacting and relating with others. In any language-related activity, however, a child is typically using both receptive and expressive language.

A marked or extreme limitation in speech functioning under the tables in SSR 98-1p leads to a marked or extreme limitation in "Interacting and relating with others," even if all other aspects of that domain are less than marked in severity. Our definitions of "marked" and "extreme" limitations explain that a child's daily functioning may be seriously (or very seriously) limited even when an impairment limits only one activity. This is the case with speech impairments, because communicating is a major activity in "Interacting and relating with others" and communicating involves the activity of speaking intelligibly.

SOCIAL SECURITY
Office of Operations

January 14, 2014

The Honorable Sam Johnson
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your November 8, 2013 letter requesting additional information to complete the record for the hearing on Puerto Rico. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or have your staff contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

Beatrice M. Disman
Regional Commissioner, New York Region

Enclosure

Questions for the Record
For the September 19, 2013 Hearing
On Puerto Rico

Questions from Chairman Sam Johnson

1. **In 2006, the Puerto Rico Department of Treasury stopped paying certain bills for the Disability Determination Services (DDS) yet the Social Security Administration (SSA) is still paying some of the DDS's bill directly. How often has the SSA had to take over the direct payment of a DDS's bill for a State or Commonwealth?**

   We have never had to pay DDS invoices for any other State, Commonwealth, or the District of Columbia to the extent we paid DDS bills for Puerto Rico. In a very few cases over the years, we have had to help States out. For example, in the mid-1990s, we had to pay for the systems maintenance contract and some other related bills for the District of Columbia DDS.

2. **In your testimony, you indicate that there are a number of other Federal and State examiners processing Puerto Rico's work. The SSA has the authority to make disability decisions if a State is failing to make decisions in accordance with the regulations. Under what conditions would you consider federalizing the disability determination process in a State or Commonwealth? What additional tools in the statute would enhance the ability to ensure compliance by a DDS?**

   Section 221(b) of the Social Security Act (Act), 42 U.S.C. § 421, and our regulations set forth the conditions under which we could federalize a DDS. We may federalize a DDS if we find after notice and opportunity for a hearing that it has substantially failed to make disability determinations in a manner consistent with the Commissioner's regulations and other written guidelines. The Federal assumption of the State's disability determination function could not take place until 180 days after the finding of substantial failure and until after: 1) we develop a plan and procedures to provide the affected DDS employees preference over any other individual in filling an appropriate employment position; and 2) the State has made fair and equitable arrangements to protect the interests of employees displaced by the federalization of the DDS. Under our regulations, we may make a finding of substantial failure only after we have provided the DDS technical and managerial support to improve its performance. 20 CFR 404.1670.

   We believe that current statutory authority in section 221 of the Act provides adequate statutory tools. Moreover, we believe it reflects congressional intent that the States continue to administer the disability determination function, with Federal oversight in performance criteria, fiscal control procedures, and other rules designed to assure equity and uniformity to State agency disability determinations.

3. How are employees trained to recognize fraud? Please be as specific as possible. How often does that training occur?

We emphasize detecting and investigating program fraud. We train our front-line employees, including claims representatives in our field offices and disability examiners in the State and Commonwealth DDSs, during their initial training program. Furthermore, all employees receive continuing training in the form of mandatory annual security reminders, programs and policy issuances, videos on demand, and office visits by executives from SSA and the Office of the Inspector General (OIG).

When our field office employees uncover potential fraud while performing daily responsibilities, they are instructed to report all (non-SSA employee) fraud allegations to the OIG Office of Investigations Field Division using the online electronic referral form, e8551. We provide periodic reminders to employees on how to fill out the e8551, and maintain policy to instruct employees on its use.

The following are some recent examples of national and New York Region training initiatives:

- **August 21, 2013:** The Deputy Commissioner for Operations issued a broadcast message to all Operations staff, focusing on the importance of identifying and referring fraudulent activity. The message included a list of our fraud reporting mechanisms and how they should be used.

- **July 2013:** All Puerto Rico DDS employees completed annual mandatory security awareness training, which we provide pursuant to the Federal Information Security Management Act. This session included a detailed discussion of how to detect and refer cases involving fraud and similar fault.

- **May 2013:** The Puerto Rico DDS conducted a fraud prevention refresher training for its staff.

- **January 2013:** A monthly Operations security training initiative, titled "Think Twice First," dealt with the importance of reporting fraud through our agency's processes. This training session was mandatory for all of Operation's front-line employees. It stressed the importance of identifying potential fraudulent situations and referring them to the OIG.

- **December 11, 2012:** The New York Region issued policy guidance to all of its offices, announcing the formation of a Cooperative Disability Investigation Unit in Puerto Rico. This guidance included tips and reminders regarding the fraud referral process.

- **August 2011:** Mood Disorder Training was conducted for the Puerto Rico DDS and all Office of Disability Adjudication and Review offices in the Commonwealth. A significant portion of this training focused on tools our employees should use to evaluate questionable medical evidence, detect potential fraud and similar fault, and refer cases for investigation.

- **April 2011:** The New York Region issued a special fraud message to all SSA components that were processing or reviewing claims from Puerto Rico. It asked those components to be alert to potential fraudulent activity and to refer those cases to the OIG where appropriate.

Additionally, each region hosts a Regional Anti-Fraud Committee that meets to discuss and promote ongoing anti-fraud initiatives. The Committee sessions provide an opportunity to review the nature of the fraud referrals from SSA components and discuss techniques to encourage referrals and streamline our processes. Also, the Committee shares ideas regarding areas that have potentially fraudulent activity that the OIG should examine.

4. **DDS examiners make decisions based on medical evidence submitted by doctors, yet that evidence has to be consistent with the claimant's allegations and other medical evidence in the file. With regards to the Puerto Rico disability fraud scheme, was every document placed in these files fabricated? As three doctors were among those arrested in Puerto Rico, what is the nature of the review DDSs and ALJs are required to do before accepting medical evidence from a doctor? How is compliance with these instructions, along with instructions for the weighing of evidence, enforced?**

As I mentioned in my testimony, we will review at least 6,600 disability applications in which we awarded benefits based, in part, on medical evidence supplied by the indicted doctors. In redetermining these cases, we will disregard the tainted medical evidence. If the remaining evidence does not support our original allowance, we will suspend the benefits and provide an opportunity to submit additional medical evidence prior to issuing a final determination.

Based on our recent experience, most of these applications had medical evidence from doctors who were not implicated in the fraud scheme. At this point in our review, we cannot predict the number of continued benefits based on the remaining evidence in file.

Our regulations set forth the criteria for weighing medical evidence, including opinion evidence. See, for example, 20 CFR 404.1520b, 404.1527, 416.920b, and 416.927. We require disability decision-makers to follow these criteria when deciding a disability claim, and provide relevant training to assist them. For example, in August 2011 we provided mood disorder training that included instructions regarding the appropriate sources and use of evidence in establishing medically determinable impairments, evaluation of symptoms, assessing credibility, and medical source opinions.

5. **What is the cost per case at the initial, reconsideration, hearing and Appeal Council levels? If possible, for initial decisions, please provide a separate break out of costs for those cases processed by the State DDS, Extended Service Teams, and Federal component costs. Please provide these costs for Fiscal Years 2011, 2012, and 2013.**

The table below provides the total agency cost per case of claims at the initial, reconsideration, hearing, and Appeal Council levels for fiscal year (FY) 2011 and FY 2012. FY 2013 data is not yet available. We cannot provide a break out of costs for cases processed by the State DDS, Extended Service Teams, or Federal disability processing units.

Level	Unit Cost FY 2011	Unit Cost FY 2012
Initial Disability Claims	$1,058	$1,036
Reconsiderations	$ 679	$ 666
Hearings	$2,752	$2,771
Appeals Council Reviews	$1,405	$1,181

6. **During the hearing, you discussed a number of ways Puerto Rico is different from the rest of the country. How do you explain the difference in award rates in Puerto Rico compared with the rest of the nation? Also, what explains the increase in initial awards from 43 percent in 2008 to over 59 percent in 2009, and 65 percent in 2011?**

Puerto Rico is different from the rest of the country in several ways that could potentially contribute to a higher award rate. When compared to the rest of the country, the population in Puerto Rico has the following characteristics that are associated with a higher likelihood of an award:

- **Older ages.** According to the data published in our 2012 Annual Statistical Report on the Social Security Disability Insurance Program, about 76 percent of disabled worker beneficiaries in Puerto Rico are ages 50 or older compared to only about 71 percent in the United States.

- **Low education levels.** According to the Census Bureau's 2012 American Community Survey, approximately 27.4 percent of the Puerto Rico population ages 25 and older has not attained a high school degree compared to only approximately 13.8 percent in the United States.

- **Higher Prevalence of Disability and Poor Health.** According to the 2012 American Community Survey, approximately 18.1 percent of people in Puerto Rico ages 18 to 64 report a disability compared to only approximately 10.1 percent in the United States. Similarly, the 2012 Centers for Disease Control Behavioral Risk Factor Surveillance System data show approximately 36.1 percent of the population in Puerto Rico is in poor or fair health compared to only approximately 16.9 percent in the United States.

The alleged fraud that is under investigation now may have also affected award rates. We are carefully reviewing cases and will know more about the impact of the alleged fraud after we complete the investigation.

SOCIAL SECURITY

Office of Disability Adjudication and Review

MAR 25 2014

The Honorable Thomas R. Carper
Chairman, Committee on Homeland Security and
Governmental Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Thank you for your December 20, 2013 request for additional information to complete the record for the hearing on our disability hearing process. Enclosed you will find the answers to your question and Senator Coburn's questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

Debra L. Bice

Judge Debra L. Bice
Chief Administrative Law Judge

Enclosure

Questions for the Record
Submitted to Hon. Debra L. Bice
For the October 7, 2013 Hearing
On the Disability Hearing Process

Question from Chairman Thomas R. Carper

1. **Investigations Into Huntington, West Virginia Situation**

Four members of the Committee released an investigative staff report in October ("How Some Legal, Medical, and Judicial Professionals Abused Social Security Disability Programs for the Country's Most Vulnerable: A Case Study of the Conn Law Firm"). The report, released in conjunction with a Committee hearing on October 7th, details the incidents associated with the Social Security Administration (SSA) disabilities programs Administrative Law Judge office in Huntington, West Virginia.

Has either the SSA Office of Inspector General or Department of Justice launched a criminal investigation into the Huntington, West Virginia case, as described by the October 9th hearing? Has SSA taken administrative action, or launched an administrative investigation, in response to the situation in Huntington West Virginia?

Yes. The Office of the Inspector General (OIG) opened an official investigation in 2011. That investigation remains open. I am aware that the OIG has been working in conjunction with the U.S. Attorney's Office in West Virginia.

Also, the agency has taken administrative action where appropriate. For example, the agency has made personnel changes, taken steps to redress claims of retaliation, and initiated the process for redetermining specific cases. The agency believes other actions are necessary. Regretfully, the agency cannot take those actions until the criminal investigations are complete or necessary clearances received.

Questions from Senator Tom Coburn

1. **The Committee's Report found misconduct in the Huntington Office of Disability and Review ("ODAR"), including problems with case management and self-assignment of cases, was well known within the office for at least the last ten years, and for at least five years these problems were raised to the regional level without resolution.**

   a. **Please explain why questions raised about b6 and b6 were not addressed.**

   I assumed the responsibilities of Chief Administrative Law Judge (CALJ) in January 2011. Prior to that time, I worked in the Kansas City, Missouri Hearing Office as the Hearing Office Chief Administrative Law Judge.

   Allegations regarding b6 came to my attention after I became CALJ. Specifically, in the middle of January 2011, I became aware that an online newspaper, West Virginia News, printed a story alleging collusion between b6. My office promptly took steps to determine the merit of those allegations. Associate Chief Administrative Law Judge, Paul Lillios, directed the Regional Office to conduct an investigation into the allegations.

   Not long after the Regional Office began to review the allegations, the OIG opened an official investigation and directed the agency to stop its internal investigations. Thereafter, the Committee began its investigation. Since that time, my office has fully cooperated in not only the OIG investigation, but also this Committee's investigation.

   b. **Please explain whether, and if so how, the fact the Huntington ODAR was one of the top producing offices in the nation affected the way the Social Security Administration (the "Agency") handled these problems.**

   The production level of the Huntington Hearing Office, or any other office, does not play a factor in how I address allegations of wrongdoing.

2. **Please explain what, if anything, top agency officials, such as b6 should have done differently after he was told repeatedly b6 misconduct in the early 2000s. Evidence of b6 knowledge can be found at Committee Report Exhibits 12, 38, and 61.**

   I have read the Committee's Report as well as the exhibits to that Report. The Report and exhibits demonstrate that b6 took action when he became aware of potential time and attendance violations by b6 during his tenure as a Regional Chief ALJ. Specifically, he instructed the HOCALJ to hold accountable. With regard to b6 cancelling hearings, he reported his

concerns and requested action, including discipline. (Exhibit 35) At that time, b6 did not have the authority to initiate any discipline against an ALJ.

3. **Please describe in detail the change you assert was made to close a "technical loophole in [y]our electronic case management system that allowed b6 to assign cases to himself in violation of agency policy," including how it will prevent an ALJ from assigning cases to themselves in the future.**

The change involved restricting permissions based on unique personal identifiers, as well as monitoring. Accordingly, line ALJs do not have the electronic ability to assign or reassign a case to themselves or any other line ALJ consistent with our long standing policy.

4.

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EX. 66

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5. **The agency asserts the Administrative Procedures Act ("APA"), which gives ALJs "qualified judicial independence," can be an impediment to disciplining ALJs.**

   a. **Please explain qualified judicial independence, and whether misinterpretation by certain ALJs allowed them to believe they had the authority to disregard or break laws and regulations.**

   ALJs "do not exercise the broadly independent authority of an Article III judge, but rather operate as subordinate executive branch officials who perform quasi-judicial functions with their agencies." *Authority of Education Department Administrative Law Judges in Conducting Hearings*, 14 Op. Off. Legal Counsel 1, 2 (1990), *see also Nash v. Bowen*, 869 F.2d 675, 680 (2d Cir.), *cert. denied*, 493 U.S. 812 (1989) ("An ALJ is a creature of statute and, as such, is subordinate to the [Commissioner] in matters of policy and interpretation of law.").

   Because ALJs are subject to the policies and regulations of their employing agencies, courts refer to an ALJ's decision-making authority as "qualified decisional independence." *See, e.g.*, *Nash v. Califano*, 613 F.2d 10, 15 (2d Cir. 1980) ("It is clear that these provisions confer a qualified right of decisional independence upon ALJs.").

   "Qualified decisional independence" means that ALJs must be impartial when conducting hearings. *See* Final Rules for Setting the Time and Place for Hearing Before an Administrative Law Judge, 75 F3d. Reg. 39154, 39156 (July 9, 2010). ALJs must decide cases based "on the facts in each case and in accordance with agency policy as laid out in regulations, rulings, and other policy statements." *Id.* The decisions of ALJs are "free from agency pressure or pressure by a party to decide a particular case, or a particular percentage of cases, in a particular way." *Id.*

   Notwithstanding the clarity of the law, some ALJs believe that, among other things, they are not required to follow agency policy because of "judicial independence." When we become aware that an ALJ holds this mistaken belief, we take appropriate steps to correct the ALJ's understanding. Such steps vary based on the particular facts, and can include training, directives or disciplinary action.

   b. **Was qualified judicial independence a barrier to address concerns raised about , including , practice of assigning cases to himself and falsifying time and attendance?**

   Qualified decisional independence does not prevent appropriate management oversight of SSA's hearings operation or prevent SSA from establishing administrative practices and programmatic policies that ALJs must follow. *See Brennan v. Dep't of Health & Human Servs.*, 787 F.2d 1559 (Fed. Cir. 1986).

c. In your statement, you described the Merit Systems Protection Board ("MSPB") process for reprimanding or terminating an ALJ. Do you believe this process too onerous?

Should the agency believe that an ALJ's behavior requires disciplinary action beyond a reprimand, the agency must petition the Merit Systems Protection Board (MSPB) for a finding of good cause. *See* 5 U.S.C. § 7521.

In my written statement, I noted that the process of seeking the removal of an ALJ spans years and consumes significant resources. *See* page 10. Not only must the agency dedicate resources to litigating the disciplinary action, but also, in removal cases where the agency has determined that the ALJ cannot remain in the office, the agency must pay the ALJ's full salary and benefits.

By way of example, in the summer of July 2011, I signed a complaint seeking the removal of an ALJ. Following a lengthy discovery period and hearing, the presiding ALJ appointed by the MSPB issued the Initial Decision finding good cause to remove the ALJ in October 2012. As of January 2014, the MSPB has not yet issued a final decision on this case. That particular ALJ has been on administrative leave and has collected a full salary and benefits, although performing no work on behalf of the American public, since July 2011.

d. Please explain what improvements can be made to the discipline process for ALJs to ensure that ALJs, like b6 are held accountable for misconduct.

As I noted above, the time and resources required to process a disciplinary action against an ALJ is a concern for the agency. The agency is open to exploring options to reduce the processing time and necessary resources.

6. In your statement you praise b6 for taking "significant steps to ensure that ALJs who refused to do their jobs properly or who otherwise betrayed the public trust would be held accountable." Please explain how this statement squares with the findings of the Committee's Report that b6 knew of b6 misconduct and did not seek disciplinary action.

In my statement, I note that when Judge Cristaudo became Chief Judge, he focused on strengthening the hearings operation. *See* page 10. I then highlighted a few of the significant initiatives Judge Cristaudo undertook to manage the ALJ corps.

I have read the Committee's Report as well as the exhibits to that Report. The Report and exhibits demonstrate that Judge Cristaudo, during his tenure as a Regional Chief ALJ, took action when he became aware of potential time and attendance violations by b6 Specifically, he instructed the HOCALJ to hold b6 accountable. With regard to b6 cancelling hearings. b6

reported his concerns and requested action, including discipline. (Exhibit 35). At that time, Judge Cristaudo did not have the authority to initiate any discipline against an ALJ.

7. **In your statement you note that "[w]e also issued a series of national reminders about the importance of adhering to long-standing policies, including case assignment and case rotation." As the Committee's Report details, b6 also sent reminders when b6 actions came to light, but the Agency continued to turn a blind eye. Please explain what the Agency has done to ensure that the case assignment and rotation policies are not just publicized, but also enforced.**

   Issuing national reminders to all staff within the hearings operations is an important step for enforcing all agency policies, including the policies regarding case assignment. When employees are reminded repeatedly of the policies, they can more easily spot policy deviations. The "See Something, Say Something" campaign complements these reminders, by encouraging employees to raise policy deviations to the attention of the appropriate officials.

   Additionally, with specific regard to case assignment, the agency made technical changes to its electronic case processing system. Those changes further enforce the case assignment policies. The agency also monitors data on case assignments and dispositions. When the data suggests that there may be a violation of agency policy, we take appropriate steps to ensure compliance.

8. **Our investigation found that b6 sought doctors with suspended or revoked licenses in other states to provide medical opinions to the Agency. Under existing rules, the Agency could not use a medical doctor with a suspended or revoked license. However, the agency does not require the same standard for medical doctors hired by claimants. Please explain what steps the Agency will take to review this policy.**

   The Social Security Act requires agency adjudicators to "consider all evidence available" in determining whether an individual qualifies for disability benefits. *See* 42 U.S.C §423(d)(5)(B). Existing law does not permit us to reject existing evidence submitted by a claimant on the basis of the provider's suspended or revoked license. The agency is continuing to evaluate the issue of medical source licensure and how any potential changes to the current approach would affect the integrity and efficiency of disability decisions.

9. **The Agency also does not bar attorneys with past disciplinary problems from representing claimants. For example, public news articles assert A L was removed by a state court judge from representing a murder suspect in 1997 for breaking Tennessee rules of professional responsibility; he was reported to the Board of Professional Responsibility in Tennessee; and in 2002 he was investigated for professional misconduct in the United States Veterans Appeals Court and later submitted his resignation to that Court's bar. Yet, A L is still allowed to represent clients before the Agency.**

   a. **Please explain whether the Agency should have stricter standards for representatives who practice before it.**

   The Social Security Act establishes the standards for recognizing attorneys as claimant representatives. *See* 42 U.S.C. §406 (a)(1). "An attorney in good standing who is admitted to practice before the highest court of the State, Territory, District, or insular possession of his residence or before the Supreme Court of the United States or the inferior Federal courts, shall be entitled to represent claimants" before the agency. *Id.* Accordingly, pursuant to statute, the agency must recognize an attorney who meets those standards as a claimant representative.

   Because the standards for recognizing claimant representatives are statutory, only Congress can change them. In the past, Congress has taken this route. For example, the Social Security Protection Act of 2004 gave the agency the authority, after due notice and the opportunity for a hearing, to refuse to recognize those attorneys who have been disbarred from any court or bar to which he or she was previously admitted to practice. *Id.* at §406 (a)(1)(A)(B).

   b. **Please explain whether the Agency would be aided by having a lawyer representing the government before the ALJ who could ensure that a case is ready for hearing and point out problems with medical and legal professionals submitting evidence to the court.**

   In August 1982, the agency published regulations establishing the Social Security Administration Representation Project, following extensive consultation with Congress. *See* 47 Fed. Reg. 36117-01 (August 19, 1982). The Project established the position of SSA representative to, among other things, review disability cases before a hearing in select offices, to initiate any necessary development of evidence, and to present the agency's view at disability hearings, if the claimant had representation. The purpose of the Project was to determine whether the participation of SSA representatives in the hearing process would: 1) help improve the overall disability adjudicatory process; 2) reduce delays in conducting hearings and issuing hearing decisions; 3) improve the quality of hearing decisions; 4) increase the productivity of ALJs; 5) achieve more uniformity and consistency in hearing decisions; and 6) reduce hearing costs. *Id.*, at 36123.

While Congress originally supported the Project, the agency received significant Congressional opposition once it began. Additionally, a United States District Court enjoined the Project. Among other things, the court held that it violated the Social Security Act by creating an adversarial proceeding in contravention of Congressional intent. *See Salling v. Bowen*, 641 F. Supp. 1046, 1072 (W.D. Va. 1986). Due to Congressional opposition, general fiscal constraints, and the District Court injunction, the agency discontinued the Project. Based on this prior history, the agency believes that specific authorizing legislation is necessary in order to explore whether the participation of agency representatives is beneficial to the process.

10. Our investigation found the Agency put tremendous pressure on ALJs to write decisions, including the so-called quota in which ALJs were to decide 500-700 cases per year, and even overlooked bad behavior if an ALJ was a high producer. For example, the Committee Report documents that in Huntington ODAR, b6 b6 cided almost 1,500 cases each year and his misconduct was overlooked, while b6 decided 300 and was pushed out.

a. Do you think emphasis on reducing the backlog contributed to the lack of oversight demonstrated at the Huntington ODAR?

As I noted, I assumed the responsibilities of CALJ in January 2011. After the OIG made public its investigation in May 2011, I had clearance to address the current structure of management within the Huntington Hearing Office. My review led to significant changes.

Further, the agency does not have a "quota." We expect that among other things, agency adjudicators will provide quality, timely and policy compliant decisions. We make it clear that agency adjudicators may not disregard these expectations simply to "pay down the backlog."

b. In your statement, you describe capping the total number of cases assigned to a single judge in order to monitor performance. Please describe other steps the Agency is taking to evaluate individual judges on their performance.

In my statement, I note that the agency has capped the number of cases assigned to an ALJ during a fiscal year. *See* page 4. I further noted that we have made several changes focusing on the quality of the hearings operation. *See* page 5-9. To ensure quality, timely and policy compliant decisions from agency adjudicators, we provide numerous resources and detailed feedback to employees in the hearings operation. We also review data and information from available resources to evaluate whether agency adjudicators are meeting the agency's expectations. Shortcomings are addressed through appropriate corrective action. Sometimes an individualized training regimen is necessary. Other times management directives, counseling or disciplinary action is necessary.

We monitor the effectiveness of the corrective action through various means, including discussions with individual adjudicators and post-effectuation reviews of cases.

11. Our investigation also found that the ability to add medical records to the hearing record at any time damaged the integrity of the hearing process. Lawyers often waited until just before the hearing to submit hundreds of pages of records, or even waited until the appeals process and therefore received a higher fee for their representation. Please explain whether you support a proposal to close the record a few days prior to the hearing to prevent these abuses.

In 2005, the agency proposed to amend various aspects of the administrative review process to improve accuracy, consistency and timeliness of decision making throughout the disability determination process. *See* 70 Fed. Reg. 43590-01 (July 27, 2005). One amendment involved closing the record 20 days prior to the hearing, subject to two exceptions. *Id.* at 43596. The agency received many comments to this proposed amendment. In 2006, the agency issued a Final Rule implementing new regulations, providing, in the relevant part, the record would close five days prior to the hearing, subject to several exceptions. *See* 71 Fed. Reg. 16424-01, 16428 (March 31, 2006). The agency has referred to this process as a "soft closure" and implemented it in the Boston Region. In 2012, the agency contracted with the Administrative Conference of the United States (ACUS) to study and provide recommendations regarding closing the record at the hearing level. The agency currently is reviewing ACUS' findings and recommendations on this issue.

12. In your statement, you note that ALJs should be held to the same standards as "other federal employees." Please explain why ALJs should not be held to a higher standard, such as that outlined in the Code of Conduct for United States Judges.

In my statement, I explained that the agency strives to ensure that our ALJs adhere to "the high standards" expected of them by the agency. *See* page 10. The ALJ position is unquestionably a position of "prominence, whose incumbents usually engender great respect and whose cooperation within the office should be taken for granted." *SSA v. Steverson*, 111 M.S.P.R. 649 (2009). *See also SSA v. Manion*, 19 M.S.P.R. 298, 302 (observing Initial Decision's conclusion that ALJs "occup[y] a high and prominent Federal office"). Because of the high standards associated with the ALJ position, the agency will address any conduct that "undermines public confidence in the administrative adjudicatory process." *See Long v. Soc. Sec. Admin.*, 635 F.3d 526, 535 (Fed. Cir. 2011).

I then explained that through litigation, the agency confirmed ALJs must adhere to the same standards of conduct as other employees. For example, the agency confirmed that ALJs were required to follow agency policies, including policies regarding working at home, use of government equipment and participation in EEO complaints. *See, e.g., SSA v. White*, 113 L.R.P. 17261, CB-7521-07-002-T-1 (April 22, 2013) (initial decision), *aff'd* 119 M.S.P.R. 390 (2013) (Table) (unbecoming conduct and failure to follow work at home procedures); *SSA v. Steverson*, 111 M.S.P.R. 649 (2009) (lack of candor, misuse of

agency title, and misuse of equipment); *SSA v. Adams,* 108 L.R.P. 30679, CB-7521-07-002-T-1 (May 9, 2008) (initial decision), *aff'd* 344 Fed. Appx. 619, 2009 WL 2952182 (Fed. Cir.) (EEO participation).

Further, ALJs, as executive branch employees, are subject to the strict ethical provisions articulated in Standards of Ethical Conduct for Employees of the Executive Branch. *See* 5 C.F.R. Part 2635. These Standards require, among other things, that ALJs shall place their loyalty to the Constitution, the laws and ethical principles above private gain, and avoid impropriety or the appearance of impropriety. They also require that ALJs shall act impartially and not give preferential treatment to any private organization or individual, and that ALJs shall not, directly or indirectly, solicit or accept a gift from a prohibited source or given because of the employee's official position unless excepted by regulation. ALJs are also subject to the Hatch Act, which relates to the partisan political activities of Federal employees, and required to file Financial Disclosures.

13. **In your statement you note that you launched a campaign called "if you see something, say something" and have encouraged employees to come forward to report abuse. However, the Committee's Report made troubling findings of retaliation by Agency officials against those who report misconduct. My office continues to receive calls and e-mails of concern from Agency employees who believe they cannot come forward for fear of retaliation. Please explain how the Agency will ensure that retaliation – such as that experienced by members of our first panel – will be prevented and, if it occurs, swiftly corrected.**

The agency has strong anti-discrimination and anti-harassment policies that specifically address retaliation and reprisal. As directed by those policies, management officials take appropriate action to address any known retaliation. To the extent individuals contact you with claims of retaliation, please feel free to provide me or OIG with such information. I have personally taken corrective action in the Huntington Hearing Office to protect employees.

Further, the "See Something, Say Something" program launched by Deputy Commissioner Glenn Sklar encourages employees within the Office of Disability Adjudication and Review to raise concerns about fraud, waste or abuse to the OIG. Complaints to OIG can be anonymous.

14. **For years, the Agency continued to deny a number of allegations made by whistleblowers that were eventually proven in the Committee's Report. It was not until the Committee started investigating that the Agency began to address the problems. Please explain how you can assure the American public this type of misconduct and failure of management to punish it will not happen again?**

As I explained above, my office began to investigate this matter prior to the Committee's involvement. Moving forward, the agency will continue to review data and information from available sources for anomalies or other issues. The agency then will continue to investigate any anomalies or allegations of wrongdoing, and take any necessary action.

15. Please explain what Congress can do to help the Agency strengthen its program integrity efforts.

We are best able to accomplish our program mission and provide excellent stewardship when Congress invests in us with sufficient funding. The Consolidated Appropriations Act, 2014, which the President signed on January 17, will provide us with $11.697 billion for our Limitation on Administrative Expenses account, including $1.197 billion for program integrity work. The $1.197 billion for program integrity is the same level authorized by the Budget Control Act of 2011 (BCA). This funding will give us the ability to complete more CDRs, allowing us to save billions of taxpayer dollars, and set the stage to complete even more CDRs in FY 2015.

Moreover, the FY 2015 President's Budget includes full funding of the BCA level of program integrity work in FY 2015. Additionally, beginning in FY 2016, the budget includes a legislative proposal that would provide a dependable source of mandatory funding to significantly ramp up our program integrity work. These mandatory funds would replace the discretionary cap adjustments authorized by the BCA. These funds would be reflected in a new account, the Program Integrity Administrative Expenses account, which would be separate, and in addition to, our Limitation on Administrative Expenses account. The program integrity funds would be available for two years, providing us with the flexibility to aggressively hire and train staff to support the processing of more program integrity work. We encourage you to support this proposal.

7 pages
withheld
Ex. b6

SOCIAL SECURITY

Office of Disability Adjudication and Review

MAR 2 5 2014

The Honorable Thomas R. Carper
Chairman, Committee on Homeland Security and
Governmental Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Thank you for your December 20, 2013 request for additional information to complete the record for the hearing on our disability hearing process. Enclosed you will find the answers to Senator Coburn's questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

Patricia A. Jonas

Judge Patricia A. Jonas
Executive Director
Office of Appellate Operations
Deputy Chair
Appeals Council

Enclosure

Questions for the Record
Submitted to Hon. Patricia A. Jonas
For the October 7, 2013 Hearing
On the Disability Hearing Process

Questions from Senator Tom Coburn

1. **You testified in front of the Committee last year regarding the report released by the Minority Staff of the Permanent Subcommittee on Investigations. That investigation reviewed 300 randomly selected case files for claimants in three different counties. In both the 2012 Report and the recent Huntington Office of Disability and Review ("ODAR") Report, we found that Administrative Law Judges ("ALJs") relied on questionable medical evidence.**

a. **Please explain whether you believe problems with reliance on questionable medical evidence are more widespread than people realize.**

The fundamental rules of the Social Security program provide that individuals applying for a benefit must establish by a preponderance of the evidence that they are eligible for those benefits. In order to prove that they are disabled, the individual must bring to the agency's attention any information the agency can use to reach conclusions about the impairment and its effect on the ability to work on a sustained basis. The information that the claimant submits may be supplemented by other relevant evidence that is developed by the agency. A variety of medical evidence types are considered in determining whether an individual is disabled. This includes objective medical evidence, other evidence from medical sources, statements regarding the claimants' activities, impairments and restrictions, and opinions from State Agency medical and psychological consultants based on their review of the evidence. Testimony from medical and vocational experts who have reviewed the record may also be considered. In addition, if the evidence that the individual submits appears incomplete or inconsistent, the agency may obtain an examination in order to gather more information to assist in making a determination or decision on the claim. While agency rules permit all evidence provided or obtained, including incomplete or inconsistent evidence, to be considered in making the decision, such evidence must be evaluated pursuant to agency rules. An adjudicator when making a disability decision should rely upon no single piece of evidence, but rather, should rely upon the record as a whole. For example, Exhibit A-2 of the October 7, 2013 Senate Report (Decision by ALJ Andrew Chwalibog) provides a good example of how an ALJ followed Social Security policy when evaluating a medical report and opinion submitted by the representative (report from Dr. Herr) along with other information. Similar examples in which the medical evidence was properly evaluated were cited in the September 2012 Minority Staff Report (pages 127 – 132).

In contrast to cases in which incomplete or inconsistent evidence is submitted, there are circumstances in which a document is of questionable validity that potentially may result in a finding of fraud or similar fault. Guidance is provided to our employees to look for

signs of these types of "questionable medical evidence," and all employees receive annual fraud awareness reminders. Additionally, there is an established process to forward fraud allegations to the Office of the Inspector General (OIG), which is responsible for fraud investigations and recommending cases to the United States Attorney's Office for possible prosecution. Our employees have been key to the identification and referral of possible fraud or similar fault in recent highly publicized OIG investigations.

We take assertions of fraud or similar fault very seriously, and continue to make important strides in protecting the program and taxpayers from these problems. The incidence of fraud tied to ALJs who willfully do not follow policy is minimal in terms of the scope of the program.

In my experience, most claimant representatives try to do their best for their clients within the scope of the law and our rules. As an example, in the June 2013 hearing before the House Oversight & Government Reform Subcommittee on Energy Policy, Healthcare and Entitlements, National Organization of Social Security Claimants' Representative's Tom Sutton commented that in their role as fiduciaries for their clients, he and his firm encourage those claimants who can work to do so because they are better off financially when employed. Also in my experience, most agency employees follow our rules and those who do not, do so because the rules and case scenarios can be complex and expertise must be developed, not because they desire to defraud the program. For this reason, the Office of Appellate Operations works closely with our colleagues to identify error reasons and deliver relevant training.

With a program of this size, we realize there will always be individuals who try to perpetrate fraud, and we have zero tolerance for fraud, as even a small amount can result in big dollars. Therefore, when my staff identifies any potentially fraudulent situations, they refer them to the OIG. The agency also studied the report from the Administrative Conference of the United States and developed a proposal to require that claimants submit all evidence, not just evidence in support of a claim. After carefully studying the report and conducting internal analyses, on February 20, 2014, we published a Notice of Proposed Rulemaking that proposed to revise our regulations to require claimants to inform us about or to submit all medical evidence known to them that relates to their disability claim--both favorable and unfavorable. This requirement would be subject to two exceptions, which are for attorney-client privilege and attorney work product. We would also extend the protections afforded by these privileges to non-attorney representatives.

b. Please explain how you believe pressure from the Social Security Administration (the "Agency") to produce 500-700 cases per year was a contributing factor in what happened in the Huntington ODAR.

ALJs are senior-level employees receiving compensation consistent with an expectation that they can handle complex work in a productive environment with support from four

or five hearing office employees. It is reasonable for the American public to expect ALJs to be fully engaged.

The former situation in the Huntington hearing office was the product of fraud or similar fault centered on an individual ALJ and cannot be attributed to the 500 – 700 case disposition request. Our data reflect that there are a large percentage of ALJs who issue more than 500 legally sufficient, policy compliant decisions per year.

2. **You were in the unique position of working directly with b6 in the Huntington ODAR before being promoted to agency leadership at which point you referred to b6 -- ' See Committee Report Ex. 5. Please explain your impression of b6 from your experience working with him in the Huntington ODAR.**

I was the in the Huntington hearing office when ' was assigned there in 1990 after he completed new ALJ training. He appropriately cooperated with management in scheduling and holding hearings, preparing written instructions for the decision writers and reviewing cases. He attended training conducted within the hearing office. The disability program rules, however, are complex, encompassing the Social Security Act, regulations, Rulings, and policies. My experience was that even after training, new ALJs would have numerous discussions with other ALJs and with the decision writers in the office regarding the application of these various, governing mandates. My observation was that once b6 was aware of the broad agency policy he did not demonstrate similar interest in discussing the details about the application of these mandates in individual cases. My impression was that he was satisfied with the minimum information necessary. During my tenure in the Huntington hearing office, it did not appear to me that he deliberately failed to follow agency mandates in the preparation or issuance of his decisions.

3. **Please explain what actions you could have taken to stop b6 or other ALJs like him when you were promoted to your current position.**

My current position is Executive Director of the Office of Appellate Operations (OAO) and the Deputy Chair of the Appeals Council (AC). When a claimant disagrees with an ALJ decision (generally a denial or a partially favorable allowance), the claimant may file a request for review with the AC. The AC appropriately may decide to deny the request for review, dismiss the request for review, or grant the request for review. If the AC grants a claimant's request for review, after such review the AC will either remand the case for further development/proceedings at the ALJ level or issue a decision.

The Social Security regulations also authorize the AC to review certain cases on our own-motion, before a claimant is paid benefits. However, the regulations prohibit the AC from selecting a case for own-motion review based either on the identity of the ALJ or the hearing office. If a case is selected for own-motion review, the AC also can either remand the case for further development or issue a decision. In 2010, we began the operation of the Division of Quality (DQ) in the AC and began to randomly select

favorable decisions for possible own-motion review pursuant to agency regulations. Several of b6 decisions came to us from this random sample review, and our staff began to identify a pattern that would warrant further review. Ultimately, we conducted a focused review of the decisions from several of the Huntington ALJs that allowed us to identify anomalies (duplications, copy and paste language) in the medical reports that were provided and in the repeated boilerplate language used by ALJ b6 in his decisions.

Under agency regulations, a focused review may be conducted after effectuation of the decision. The information collected and assessed during a focused review appropriately varies from review to review. When conducting a focused review of an individual ALJ, the DQ uses survey protocols to collect information during its review of a random sample of cases and to obtain an overall picture of the cases under review. If DQ identifies a concern, it conducts a more in-depth review. DQ reports its concerns from focused reviews to an executive management board that determines a course of action, including training and mentoring for an ALJ. The focused review information is later shared with the individual ALJ, and an individualized training plan is developed to address the specific area of policy non-compliance.

When the AC identifies a pattern that suggests misunderstanding or misapplication of a policy by a number of ALJs, we work with our colleagues to develop training for all ALJs. Since 2012, ODAR adjudicators have received training in complex areas including assessing credibility, evaluating medical source statements, Residual Functional Capacities (RFCs), and dismissals. We will continue training in FY 2014 to cover topics such as drug addiction and alcoholism, child disability, and articulating the RFC.

In addition to training, ALJs receive individual feedback about their remanded decisions and how they are doing compared to other ALJs via a tool called "How MI Doing?". The "How MI Doing?" tool gives adjudicators extensive information about remands, including the reasons for remand and information on performance in relation to other ALJs in the office, region, and nation. We currently are developing training modules related to each of the identified reasons for remands that we will link to the "How MI Doing?" tool. This will allow an ALJ immediate access to training materials regarding the issues set forth in a remand order.

Additionally, when a review identifies a policy related issue that is applied inconsistently by a significant number of adjudicators or by the Federal courts, we evaluate whether there is a misunderstanding of the policy or whether a policy clarification is needed. When errors appear to be based on a misunderstanding of the policy, we will recommend focused training on the issue or will make the necessary policy clarifications in sub-regulatory guidance. When the policy itself appears to be the issue, we will work with other components to address the necessary policy change.

Moreover, if AC review reveals issues of possible fraud or similar fault, the AC appropriately refers those matters to the OIG for further investigation. Regarding ALJ

b 6 when AC review revealed anomalies in decisions he issued, I appropriately referred the matter to OIG.

For many years, OAO did not receive enough resources to handle these types of quality reviews. Rather, OAO by necessity had to focus on mandatory, claimant-driven workloads like requests for AC review and Federal court cases. OAO's remands on claimants' requests for review do provide feedback to ALJs. However, the quality reviews described above are essential to identifying anomalies that may alert us to circumstances such as the former situation in the Huntington hearing office, including situations where our adjudicators inadvertently misapply policy and are in need of focused training. Quality reviews like those described above identified anomalies in ALJ Daugherty's decisions, and these anomalies were reported to the Office of the Inspector General. With continued funding, the agency will be able to maintain and enhance quality review initiatives.

4. **In all of b 6 opinions, he would use boilerplate language to dismiss the opinion of every doctor but those provided by b 6 . Nor did b 6 ever consider the previous two cases the Agency decided unfavorably at significant expense.**

   a. **What steps should the Agency take to ensure proper review by ALJs of prior Agency decisions?**

When the agency receives a new disability claim, it generally is sent to a State disability determination service (DDS) to develop the record regarding the claim and make an initial determination of whether the individual is disabled. We rely upon the 54 State and territorial DDSs to develop medical evidence and initially determine whether claimants are disabled (or whether program beneficiaries continue to be disabled). If the claimant is dissatisfied with the initial disability determination, agency regulations provide for up to three levels of administrative review. Generally, a claimant can ask the DDS to reconsider the claim. If denied at the reconsideration level, then the claimant may seek a hearing before an ALJ. If denied again at the ALJ level, then a claimant may request a review by our AC. If the AC denies the request for review (or if the AC grants the request and issues a decision), the claimant may appeal to Federal district court. Social Security policy requires ALJs and the AC to consider the medical opinions of the DDS physicians who participated in making the initial and reconsideration determinations.

However, under agency regulations, ALJs conduct *de novo* hearings; in other words, they may consider or develop new evidence, and they are not bound by DDS decisions. Additionally, in most cases the ALJ has received additional medical evidence and has heard testimony from the claimant and possibly one or more expert witnesses before issuing a decision. Quality reviews identify ALJs who do not follow agency policies, with or without intent.

b. Please explain whether the Agency should be required to provide a more robust written decision for its denials at the initial level and at DDS.

As an ongoing effort to improve our service to the American public, we took steps at the DDS level to improve the quality and consistency of our disability claims process. For example, we developed the electronic Claims Analysis Tool, or eCAT. eCAT is a policy compliant, web-based application designed to assist DDS adjudicators in their decision-making process. The tool aids in documenting, analyzing, and adjudicating the disability claim according to agency regulations. All DDS adjudicators must use eCAT. The eCAT tool also produces the "Disability Determination Explanation" (DDE), which is a detailed record of the pertinent documentation and analysis necessary to support the determination. This record, which is uploaded to the claimant's electronic folder, enables the ALJ to understand the DDS examiners' actions and conclusions throughout the development and adjudication of the claim at the first two administrative levels. This DDE, consequently, is a part of the record considered by the ALJ.

c. Please describe any other changes the Agency has implemented since the misconduct at Huntington ODAR came to light that will ensure previous Agency decisions are not ignored.

In addition to other changes and improvements, in the past several years the agency has developed a robust and sophisticated data analysis and feedback process. This process captures key claims data, visualizes the results, and delivers feedback for further analysis. This data-based feedback has helped the agency and adjudicators increase policy compliance, dramatically reducing errors in claim determinations. At the end of my answers, I have attached a report that elaborates on the ways we use these data.

Further, in 2010, we established the DQ within OAO. In its first three years, the DQ implemented the random sample case selection provisions of the regulations which permitted the DQ to consider a random sample of unappealed hearing decisions for possible own-motion review. These reviews address concerns in particular claims, but they also support consistent, legally sufficient, and policy compliant decision-making throughout the disability adjudication process. This is possible by analyzing the adjudication of each case beginning with the initial application, collecting concrete data about recurrent issues in decision-making, making suggestions for improvements in policies and procedures, and identifying training opportunities for adjudicators and other agency employees involved in the adjudication process.

While we did not implement DQ in response to the former situation in the Huntington hearing office, I raise it in answer to your question because the work we are doing uncovered anomalies in that office, and we appropriately conveyed that information to the OIG. Although DQ's work is a relatively new process, it is evolving as we hoped it would. As is the case with any major implementation, we are continuing to refine and improve how we handle this work.

Additionally, Deputy Commissioner Glenn Sklar is emphasizing the message to employees who see something to say or do something about it. As an example of this reinforced message, I sent an email to employees explaining what the New York DDS employees observed regarding specific anomalies on disability applications from former New York City firefighters and police officers, and how these observations led to the OIG investigation and the current legal actions. The more we empower our employees to know what to look for and what to do about concerns, the stronger our program becomes.

5. It is my understanding the Agency's Division of Quality was created in 2010.

a. Please explain whether the Agency's past policy to review only unfavorable cases at the appellate level created an incentive to approve cases, since approved cases are not reviewed.

The agency has never had a policy to review only unfavorable cases. In fact, the agency has reviewed favorable decisions consistently over the years, but in much smaller numbers than the review of unfavorable cases. This was necessary because agency regulations accord each claimant the right to request AC review of an unfavorable decision, and the agency usually devoted most of our resources to that workload. Thus, the claimant's request for review has always been a mandatory workload for purposes of the agency's budget. The pre-effectuation review of favorable cases, except in rare circumstances, has been discretionary insofar as the number of cases reviewed. Although more unfavorable cases, by necessity, are reviewed by the AC, it does not appear that AC review created an incentive to approve cases.

b. Please explain why the Division of Quality was created and provide an update on the program's effectiveness.

The DQ was created to provide a more extensive quality review of hearing decisions without regard to whether the claimant wished to file an appeal. Thus far, the reviews have centered on favorable decisions. The chief purposes of the reviews are to correct decisions that are unsupported, to provide quality feedback through individual remand orders, and to provide improved training and policy guidance for all adjudicators. The reviews also enable the agency to uncover and address anomalies in adjudication determinations.

DQ's work gives a more in-depth and detailed insight into whether adjudicators and offices are making policy compliant determinations and also reveals information about third party participants that informs the agency about how our polices are working. DQ's work also uncovers anomalies that we appropriately report to the OIG.

c. Since the Division of Quality's inception, how many quality reviews has the Division of Quality performed on cases that were grants or partial grants of disability benefits and accordingly not appealed by a claimant?

In fiscal year (FY) 2011, the DQ reviewed 3,692 favorable or partially favorable cases under our regulatory random sample authority (20 CFR 404.969(b)(1)/416.1496(b)(1); in FY 2012 DQ reviewed 7,009 favorable or partially favorable cases under this authority; and in FY 2013, DQ reviewed 6,167 favorable or partially favorable cases under this authority.

6. Please explain what Congress can do to help the Agency strengthen its program integrity efforts.

We are best able to accomplish our program mission and provide excellent stewardship when Congress invests in us with sufficient funding. I understand that the Consolidated Appropriations Act of 2014 fully funded program integrity work at the level established in the Budget Control Act of 2011 (BCA). The FY 2015 President's Budget proposes additional funding at the BCA level in FY 2015, as well as a legislative proposal creating mandatory funding for the agency's program integrity work beginning in FY 2016. I concur in Chief Administrative Law Judge Bice's response regarding those matters.

Social Security Administration – Questions for the Record

Democratic Members of the Subcommittee on Energy Policy, Health Care and Entitlements
November 19, 2013, Hearing entitled "Continuing Oversight of the Social Security Administration's Mismanagement of Federal Disability Programs"

Rep. Lujan Grisham

- How often does SSA identify cases where benefits are improperly awarded or improperly denied by ALJs?
- How often does the Appeals Council reverse ALJ decisions?
- What information is gathered on un-appealed denial decisions?
- What is being done to advise individuals of their right to appeal?
- What information is collected and assessed during a focused review?

Rep. Speier

- What primary issues or topics should quality reviews focus on to evaluate ALJ decisions? (to IG)
- What additional deterrents may be implemented to help discourage bad actors from attempting to defraud the government by improperly applying for disability insurance benefits? (to IG)
- How many pre-effectuation case reviews were conducted by the Division of Quality last year?
- How many of the pre-effectuation case reviews resulted in benefits not being awarded?

Rep. Horsford

- Please provide this committee with an overview of statistics collected by the Appeals Council and Division of Quality pertaining to the quality and legal sufficiency of judges' decisions.
- How does SSA use reversals by the Appeals Council, pre-effectuation and focused reviews to identify concerns with the quality and competence of ALJs?
- What information is gathered on ALJs with low allowance rates? Provide the committee with a list of ALJs with the lowest allowance rates. Please include the office and region as well.
- How many ALJs have large numbers of reversed cases indicating deficient quality of work?

Questions for the Record
for the November 19, 2013 Hearing
on Continuing Oversight of the Social Security Administration's
Mismanagement of Federal Disability Programs

Rep. Lujan Grisham

How often does SSA identify cases where benefits are improperly awarded or improperly denied by ALJs?

We generally associate "improper denials" with our Office of Appellate Operation's (OAO) request for review workload. When a claimant disagrees with an administrative law judge (ALJ) decision (generally a denial or a partially favorable allowance), the claimant may file a request for review with OAO's Appeals Council (AC). The AC may decide to deny the request for review, dismiss the request for review, or grant the request for review. If the AC grants a claimant's request for review, the AC will either issue a decision or remand the case for further development or proceedings at the ALJ level.

However, remanding an ALJ decision does not necessarily mean the AC disagrees with the ALJ's decision to deny benefits. Rather, it can mean the AC identified an error that may not affect the outcome but which the ALJ must correct for a legally sufficient decision. Keeping this in mind, of the 176,251 requests for review the AC processed in fiscal year (FY) 2013, the AC denied the claimant's request for review in 76.87 percent of the claims, remanded 17.11 percent of the claims, and dismissed 4.15 percent of the claims. The AC issued 0.8 percent fully favorable decisions, 0.65 percent partially favorable decisions, and 0.42 percent corrective unfavorable decisions. This means the AC changed an unfavorable ALJ decision to a favorable decision in less than 1.5 percent of all requests for review.

Another AC workload that may be categorized as an "improper allowance" by an ALJ is called a bureau protest. When an ALJ issues a favorable decision, we send the claim to an operational component for the next steps, including payment. In some cases, the operational component identifies a possible technical problem with the ALJ decision that may affect payment. For example, the component may notice that the ALJ established an onset date after a claimant is no longer insured, or the component may notice earnings after the onset date that the ALJ did not address, suggesting the ALJ may not be aware of possible work after onset. In this situation, rather than moving forward with payment, the operational component will submit a bureau protest to the AC. The component must submit the protest with sufficient time for the AC to use its "own motion" authority to review the case, as explained in 20 CFR 404.969 and 416.1469. In FY 2013, the AC processed 472 bureau protests. Of these cases, the AC's actions were favorable in 6.78 percent of the cases, partially favorable in 7.20 percent, unfavorable in 17.37 percent, dismissed in 18.01 percent, remanded in 24.79 percent, and denied in 25.85 percent.

In regards to possible "improper awards," the AC has regulatory authority to review hearing decisions on its "own motion" before we pay benefits. In FYs 2011 and 2012, the Division of Quality (DQ) in OAO considered a random sample of 10,699 un-appealed favorable hearing

decisions. DQ forwarded about 75 percent of the cases for payment, which means the decision was supported by substantial evidence. DQ took "own motion" review on about 25 percent of the cases. The AC remanded many of the "own motion" cases for a new ALJ decision. Of the cases decided either by the AC or by an ALJ after remand, the initial ALJ decision was modified or changed in 11.37 percent of the cases. The new decision was less favorable in 7.35 percent of the cases. Please note that when the AC takes a case for "own motion" review, it does not mean that an ALJ incorrectly awarded benefits or that the AC disagreed with the ALJ decision. Rather, "own motion" review means that a corrective action is needed but not necessarily one that changes the outcome of the decision. In fact, sometimes a correction action results in a more favorable decision for a claimant.

How often does the Appeals Council reverse ALJ decisions?

Please see our answer to the question above.

What information is gathered on un-appealed denial decisions?

For every disability application, we gather personal information, including medical records, work and earnings history, and some non-medical information such as income and resources for Supplemental Security Income claims. We track the number of cases approved and denied. For un-appealed denial decisions, we know the number of denied applicants who reapply.

What is being done to advise individuals of their right to appeal?

The administrative review process generally includes the initial determination and three appeal levels: reconsideration, hearing before an ALJ, and AC review. Federal court review is available to individuals who have exhausted the administrative review process. At each level of the administrative review process, we provide individuals with written notice advising them of the right to appeal our decision. More specifically:

- The initial determination notice informs an individual of his or her right to reconsideration of an initial determination concerning entitlement or continuing entitlement to benefits or other issues that affect benefits.

- The reconsideration determination notice informs an individual of his or her right to a hearing before an ALJ on a reconsideration determination.

- The ALJ decision notice informs an individual of his or her right to AC review of an ALJ decision.

- The AC decision notice informs an individual of his or her right to file a civil action in the United States District Court if he or she disagrees with an AC decision.

We provide audio and printable publications that provide information about appeal rights, through our official website's Publications page (http://www.socialsecurity.gov/pubs/).

What information is collected and assessed during a focused review?

The information collected and assessed during a focused review varies from case to case and depends on whether we are reviewing the ALJ, another participant in the hearing, or a specific issue. Upon receipt of a referral, DQ creates a "survey" of information it needs to evaluate the particular subject or subject matter. For example, the survey may ask whether the decision was issued after a hearing or based solely on the record, whether the ALJ obtained vocational expert testimony, or whether the cases reviewed were remanded by the AC. DQ uses the survey questions to collect information during its review of a random sample of cases and to obtain an overall picture of the cases under review. This information helps reveal case commonalities, patterns, and possible issues for further review. If DQ identifies a concern, it performs a more in-depth review focusing on the issue(s).

Rep. Speier

How many pre-effectuation case reviews were conducted by the Division of Quality last year?

For its FY 2013 case sample, DQ reviewed 6,167 un-appealed favorable decisions, with 397 of these still pending at the end of FY 2013. Including cases pending from FY 2012, DQ completed review of 6,501 cases in FY 2013.

How many of the pre-effectuation case reviews resulted in benefits not being awarded?

For FYs 2011 and 2012, DQ considered a random sample of 10,699 cases for possible "own motion" review. DQ sent approximately 75 percent of the cases for payment. DQ took own motion review on about 25 percent of the cases. The AC remanded many of the "own motion" cases for a new ALJ decision. Of the cases decided either by the AC or by an ALJ after remand, the decision was changed to a less favorable decision in approximately 7 percent of the cases.

Of the 6,501 pre-effectuation review cases completed in FY 2013, the AC sent 72.4 percent to an operational component to process for payment, remanded 19.9 percent, and issued 501 corrective decisions on 7.7 percent.

Rep. Horsford

Please provide this committee with an overview of statistics collected by the Appeals Council and Division of Quality pertaining to the quality and legal sufficiency of judges' decisions.

For the cases it handles, OAO collects, tracks, or reviews information on: improper denials, improper awards, dismissals, remands, fully favorable decisions, partially favorable decisions, and corrected unfavorable decisions.

How does SSA use reversals by the Appeals Council, pre-effectuation and focused reviews to identify concerns with the quality and competence of ALJs?

When the AC identifies a pattern that suggests misunderstanding or misapplication of a policy, we work with our agency colleagues to develop training. Since 2012, we have trained our adjudicators in complex areas, including assessing credibility, evaluating medical source statements, residual functional capacities (RFC), and dismissals. We will continue training in FY 2014 to cover topics such as drug addiction and alcoholism, child disability, and evaluating the RFC.

In addition to training, ALJs receive individual feedback about their remanded decisions and how they are doing compared to other ALJs via a tool called "How MI Doing?" The "How MI Doing?" tool gives adjudicators extensive information about remands, including the reasons for remand and information on performance in relation to other ALJs in the office, region, and Nation. We are currently developing training modules related to each of the identified reasons for remands, which we will link to the "How MI Doing?" tool. This will allow an ALJ immediate access to training materials regarding the issues in a remand order.

When a review identifies a policy-related issue that is applied inconsistently by a significant number of adjudicators or by the Federal courts, we evaluate whether there is a misunderstanding of the policy or whether a policy change is needed. When errors appear to be based on a misunderstanding of the policy, we recommend focused training on the issue or make the necessary policy clarifications in sub-regulatory guidance. When the policy itself appears to be the problem, we work with policy components to make the necessary change.

Our reviews emphasize feedback. Most ALJs want to do a great job and welcome information to help them do so. When an AC member who is not in DQ identifies a concern, the member can refer the issue to OAO's Executive Director's office to provide feedback for ALJs . DQ reports its concerns from focused reviews to an executive management board that determines a course of action, including training and mentoring for an ALJ.

On occasion, AC review reveals potential fraud. The AC refers those matters to our Office of the Inspector General for further investigation.

What information is gathered on ALJs with low allowance rates? Provide the committee with a list of ALJs with the lowest allowance rates. Please include the office and region as well.

The enclosed table lists our ALJs with the lowest allowance rates and provides the information we gather on ALJs with low allowance rates.

How many ALJs have large numbers of reversed cases indicating deficient quality of work?

The AC very seldom reverses ALJ decisions on review. In fact, the rate is around 2 percent of its dispositions. Therefore, there would not be "large numbers of reversed cases." Furthermore, an AC reversal of an ALJ decision does not always indicate a deficiency in the ALJ decision. Sometimes the AC may issue a revised decision for reasons outside the ALJ's knowledge or responsibility, such as when new evidence is attached to the request for review.

Enclosure

SSA ALJs with an Allowance Rate of Less than 20 Percent

FY 2008 - FY 2013

Region	Current Office	Name	Allowance Rate	Dispositions	Allowances	Denials	Dismissals
Philadelphia	Norfolk, VA		18%	158	29	109	20
Philadelphia	Baltimore, MD		19%	418	81	236	101
Atlanta	Columbia, SC		0	3	0	3	0
Atlanta	Orlando, FL		13%	503	66	338	99
Atlanta	Jacksonville, FL		15%	2312	352	1219	741
Atlanta	Memphis, TN		16%	44	7	33	4
Atlanta	Jacksonville, FL		17%	293	51	153	89
Atlanta	Atlanta Downtown, GA		18%	28	5	22	1
Chicago	Dayton, OH		14%	437	62	324	51
Chicago	Cleveland, OH		16%	434	69	290	75
Chicago	Milwaukee, WI		19%	2444	465	1485	494
Chicago	Cleveland, OH		19%	1647	319	1009	318
Dallas	Dallas North, TX		9%	2504	221	1799	484
Dallas	Houston-Bissonnet, TX		10%	166	16	105	45
Dallas	Dallas North, TX		10%	2377	249	1529	599
Dallas	Houston-Bissonnet, TX		14%	1667	232	1078	357
Dallas	San Antonio, TX		15%	1822	270	1334	218
Dallas	Houston-Bissonnet, TX		15%	3015	452	1906	657
Dallas	Dallas Downtown, TX		16%	2402	393	1549	460
Kansas City	Wichita, KS		16%	293	48	178	67
Kansas City	Creve Coeur, MO		19%	3292	612	1684	996
Denver	Denver, CO		0%	1	0	0	1
Seattle	Anchorage, AK		12%	469	55	273	141
Seattle	Portland, OR		16%	474	76	290	108

Note: This table includes all administrative law judges (ALJ) who have made decisions for the Social Security Administration (SSA) any time between fiscal year (FY) 2008 and FY 2013 with a combined allowance rate below 20 percent.

1/ Excludes one dismissal due to an informal remand to the State disability determination services.

2/ ALJ no longer with SSA/Office of Disability Adjudication and Review.

Questions for the Record
For the January 24, 2012 Hearing
On Combating Disability Waste, Fraud, and Abuse

1. **In August, Congress authorized $896 million in additional funds for FY 2012 so that the agency could perform Continuing Disability Reviews (CDRs) and redeterminations. In December, Congress appropriated $758 million for this work. In response to questions for the record on September 16, 2011, you stated that you had a backlog of 1.4 million medical CDRs, but that you anticipated that with the appropriated money "we would be able to catch up on Title II CDRs by 2016." As you were able to make this projection last September, you must have had projections and plans on the drawing board to get started on the integrity work. Has the money been allocated to the front lines to get this work started? The growing backlogs of CDRs, including full medical CDRs, needs to be reduced as soon as possible. Please submit to this Subcommittee a full detailed plan for how this will be accomplished.**

   The Administration strongly supports the program integrity cap adjustments authorized by the Budget Control Act, which would put us on a ten-year path to essentially eliminate the backlog in program integrity reviews. In fact, the President's 2013 Budget urges Congress to appropriate the remaining $140 million in program integrity funding authorized under the BCA for 2012, which would save taxpayers an additional estimated $800 million.

   We plan to complete 435,000 full medical CDRs with our fiscal year (FY) 2012 appropriated program integrity funding--about 90,000 more than we completed in FY 2011. We began ramping up our program integrity work at the beginning of the fiscal year; we have allocated the necessary resources and are on track to achieve our CDR and Supplemental Security Income (SSI) redetermination targets for the appropriated funding level.

   While we will complete significantly more full medical CDRs than we did last year, we will not be able to complete as many as we would have with the level of funding authorized in the *Budget Control Act of 2011* (BCA). If we had received full BCA funding-- $896 million for FY 2012--we would have been able to complete a projected 568,000 full medical CDRs.

   Adequate funding is critical to the reduction of the CDR backlog. The BCA allows increases to the Government's annual spending caps through FY 2021 for program integrity spending, and these increases would allow us to complete substantially more CDRs at considerable savings to the taxpayers. It is important to understand that the same people who handle CDRs also handle initial disability claims. Therefore, we need an adequate number of trained employees to complete both workloads. If we do not receive increased funding for our program integrity work, it will be virtually impossible to reduce the CDR backlog.

   The FY 2013 President's Budget includes $1.024 billion for our program integrity work, consistent with the BCA. If we receive this funding on a timely basis, we plan to complete 650,000 full medical CDRs--about 215,000 more than we expect to complete in FY 2012. In

FY 2013, we estimate that every dollar spent on CDRs will yield about $9 in program savings over 10 years, including Medicare and Medicaid program effects.

Our Office of the Chief Actuary has updated its estimates based on our current CDR review and profile processes. If we received the full amounts authorized under BCA, we could become current on title II medical CDRs in 2014, two years earlier than our prior estimate.

2. **How aware are agency personnel of the Cooperative Disability Investigation program and its successes? How does the agency make sure that front line employees know about their responsibilities to find and report fraud?**

We promote awareness of the Cooperative Disability Investigations (CDI) program in several different ways. The CDI units conduct regular training with our field offices and the disability determination services (DDS) to make them aware of the CDI program and to instruct them on how to report fraud. To raise awareness of the CDI program and its accomplishments, we distribute to our field offices a monthly fact sheet that the Office of the Inspector General (OIG) publishes. Due to these efforts, the CDI program received 6,208 allegations of potential fraud in FY 2011. Of this number, approximately 64 percent came from the DDSs, 23 percent from our field office employees, and 13 percent from other sources, such as our Office of Disability Adjudication and Review, OIG, and the fraud hotline.

Our frontline employees are often the first to identify potential fraud. Field office employees routinely assess the authenticity of evidentiary documents, scrutinize statements made by applicants, use our databases and Internet tools to find discrepancies, and follow up on complaints or tips from the public.

3. **Your own policies require CDRs for 60 percent of beneficiaries within three years. What kinds of disabilities are included in this 3-year category?**

We set the three-year review, otherwise known as the Medical Improvement Possible (MIP) diary, for adult beneficiaries whose medical conditions may improve and allow them to be able to work. While the timeframe for a review depends on individual case facts, generally, the majority of beneficiaries receive a MIP diary. Although MIP diaries have historically comprised 60 percent of our diaries, our policy does not require that 60 percent of beneficiaries receive a review in three years. Examples of impairments that can fall within this category include heart failure and severe diabetes with end organ damage. By contrast, we set a seven-year review for impairments where medical improvement is not expected due to the nature of the impairment(s), such as some intellectual disabilities. Regardless of when we schedule the review, we will need the full level of program integrity funding authorized under the BCA to keep up with all of the cases that are due for a medical review.

4. I understand about five percent of beneficiaries are scheduled for a review in a 6 to 18 month time period; this is the medical improvement expected category. What conditions are scheduled for reviews within these timeframes?

We set the Medical Improvement Expected (MIE) diary for adult beneficiaries whose medical conditions will probably improve and allow them to be able to work. Whether we set an MIE diary depends on individual case facts. Examples of impairments that can fall within this category include traumatic injuries and severe bone fracture.

5. In the FY 2012 Annual Performance Plan, your message states, "We will use technology to reduce our back logs, improve service, and target our program integrity efforts. For example, we are capitalizing on advances in video technology and electronic processes." Can you elaborate on what kinds of "electronic processes" are being utilized, and how they have helped improve program integrity efforts?

We use an array of electronic processes to improve our program integrity efforts. For example, we created the Access to Financial Institutions (AFI) electronic process to automatically verify financial account balances of claimants and recipients during the SSI claims and redeterminations process. We developed AFI to address the leading cause of SSI overpayment errors--excess resources in financial accounts. We also use an electronic process to track all allegations of benefit misuse by representative payees.

We have much more work than we can complete in one year. Technology has allowed us to develop tools to prioritize our program integrity work to focus on the cases that give us the greatest return for our limited administrative dollars. We use these tools to select the most cost-effective medical and work CDRs, as well as the SSI redeterminations we should complete. As a result of these types of tools, we expect that the SSI redeterminations that we conduct in FY 2012 will save about $3.2 billion in total lifetime SSI overpayments compared to only $1.8 billion in savings if we had selected the cases randomly.

Moreover, we strive to provide the DDSs with the tools they need to quickly and accurately decide disability cases to help ensure that we pay disability benefits to those applicants who qualify. Our Compassionate Allowances initiative allows us to identify claimants who are clearly disabled because the nature of their disease or condition meets the statutory standard for disability. With the help of sophisticated new information technology, we can quickly identify potential Compassionate Allowances and then swiftly make decisions. Our Quick Disability Determination initiative 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.

We are developing other new electronic tools. For example, we are developing the Veterans Affairs (VA) Supplemental Security Record Pension Calculation for the *Medicare Modernization Act*, which will help prevent improper payments by ensuring veterans receiving VA pensions who apply for Part D Low Income Subsidy receive the most advantageous subsidy amount possible.

6. **Why has the number of CDRs performed by the SSA declined recently? How significant has the decline been? What are the lost savings as a result?**

We have steadily increased the number of full medical CDRs we complete every year since FY 2007. In FY 2012, we are completing more than double the number of full medical CDRS we completed in FY 2007. We have saved significantly more program dollars by completing more CDRs. Sustained, adequate funding is critical for us to continue this cost-effective work, because the same employees who do this work also handle initial claims and other program integrity activities.

7. **What are the future projected numbers of CDRs the Social Security Administration (SSA) expects to schedule and complete?**

In FY 2012, we expect to complete 435,000 full medical CDRs and 850,000 mailer CDRs.

The FY 2013 President's Budget includes $1.024 billion for program integrity work, consistent with the BCA. With funding at this level, we plan to complete 650,000 full medical CDRs. In FY 2013, we estimate that every dollar spent on CDRs will yield about $9 in program savings over 10 years, including Medicare and Medicaid program effects.

8. **How does the SSA select which medical CDRs are conducted each year and the percentage that are mailers?**

The number of periodic CDRs we complete each year depends on the level of funding we receive. Our annual budget request includes the number and type of CDRs we plan to complete. For cases we initiate centrally, we use one of two methods. We send some cases to the DDSs for a full medical review; others we complete using the mailer process.

We decide whether to initiate a full medical review or send a mailer after identifying those cases with a higher likelihood of medical improvement. We send cases with a higher likelihood of medical improvement to the DDS for a full medical review. We send a mailer for those cases with a lower likelihood of medical improvement to obtain more information from beneficiaries; we evaluate the information we receive to determine if there is any indication of medical improvement. If there is, we send the case to the DDS for a full medical review. Otherwise, we do not initiate a full medical review, and we schedule the case for a future CDR.

9. **The Disability program provides an essential income safety net for those who cannot work. But we also know there are those receiving disability benefits who want to work and believe they can work. Given the increase in applications for benefits during the recession and with so few coming off the rolls is the disability insurance program becoming a long term unemployment program for these people?**

The changing age distribution of the population is the main driver of long-term Disability Insurance (DI) program growth. For example, the aging of the baby boom generation into more disability prone ages accounts for a large portion of the growth in DI awards, and that

growth has been predicted for many years. Increased labor force participation among women over the past decades, which has led to an increase in the proportion of the population who meet the DI program's coverage requirements, is another important factor in the growth of the DI program.

Prior to FY 2009, we received about 1.6 million title II initial disability claims each year. Since 2009, that level has increased dramatically. In FY 2011, we received nearly 2.1 million title II disability claims. The recession played an important role in the increased number of applications; people with disabilities tend to have a higher unemployment rate than others, and long unemployment spells can make it more difficult to re-enter the work force. In a recession, people with disabilities may apply for and receive DI benefits sooner than they would in normal economic times, which could result in receiving DI benefits for a slightly longer period. To the extent that the recession may have motivated people to file DI claims based on less severe impairments that typically would not meet the definition of disability, we would expect that the average probability of an allowance should go down. That trend is exactly what we have seen. During the recession, our allowance rates have dropped at the DDS and appeals levels.

10. The SSA Office of Inspector General was able to identify high dollar overpayments that the SSA missed just by looking at it a different way. What is the SSA going to do differently in the future to make sure high dollar overpayments are identified?

The Office of Management and Budget (OMB) requires us to report on high-dollar overpayments. We base the methodology we use to detect high-dollar overpayments on a statistically valid sample of Old-Age, Survivors, and Disability Insurance payments and SSI payments, from which we conduct our payment accuracy reviews (also known as Stewardship reviews). OMB has agreed that the manner in which we detect and report our high-dollar overpayments meets the requirements, as provided in Executive Order 13520. Every quarter, we review our Stewardship data to determine if we have identified any overpayments that meet the criteria of the Executive Order for high-dollar overpayments. To date, we have not found any high-dollar overpayments.

Not every overpayment is an improper payment. For example, we do not consider overpayments resulting from legal or policy requirements as improper payments. OMB recognizes that the Stewardship data do not account for this difference but agrees that using these data provide the most efficient method to meet the intent of the Executive Order.

112th Congress

SOCIAL SECURITY

Office of Operations

July 21, 2011

The Honorable Sam Johnson
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Johnson:

Thank you for your letter of June 9, 2011, requesting additional information in order to complete the record for the April 13, 2011 hearing on the Social Security Administration's role in protecting the Social Security number and combating identity theft. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Scott Frey, Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030, who is available to meet with your staff if requested.

Sincerely,

Theresa Gruber

Enclosure

Congress of the United States
House of Representatives
COMMITTEE ON WAYS AND MEANS
WASHINGTON, DC 20515

SUBCOMMITTEE ON SOCIAL SECURITY

June 9, 2011

The Honorable Michael J. Astrue
Commissioner of Social Security
Social Security Administration
6401 Security Boulevard
Woodlawn, MD 21207

Dear Commissioner Astrue:

We appreciated hearing Ms. Gruber's testimony before the Committee on Ways and Means, Subcommittee on Social Security during the April 13, 2011 hearing on the role of Social Security numbers (SSNs) in identity theft and options to guard their privacy. In order to complete our hearing record, we would appreciate your response to the following questions:

1) The President's Identity Theft Task Force recommended that the Social Security Administration (SSA) become a clearinghouse for federal agencies that minimize the use of SSNs by the fourth quarter of 2007. What progress can you report on this recommendation?

2) What is SSA doing to end the practice of K-12 schools collecting students' SSNs and using them as authenticators?

3) How does the SSA alert or educate cardholders on the proper protection of their SSNs? Do you inform the public on how to protect their SSNs? Does the SSA conduct public outreach to institutions and businesses with respect to the display of SSNs? Does the agency provide best practices information for the handling of personal data?

4) If someone knows their SSN has been stolen or compromised, but no actual fraud has occurred to date, can the individual apply for a new number? What guidelines does the SSA follow for when a replacement SSN is issued? Can the SSA help an individual protect a stolen number?

5) The Subcommittee is interested in removing the SSN from the Medicare card and inserting another identifying number for Medicare use, much like the military is doing with its ID cards. The SSA systems would not have to make any changes except interfacing with the Centers for Medicare and Medicaid Services to identify the new number with the correct SSN already in their system. Is this the simplest way to alter the system, and if so, what are the costs and the time frames for achieving the change?

6) As you may know, the Department of Education recently proposed a rule known as the "gainful employment" ruling that would limit the use of Title IV funding at proprietary, or for-profit, colleges. This rule would employ a formula based on a student's debt and income to determine whether students at these schools meet the Department's definition of holding gainful employment after graduation. Many Members of Congress have concerns with this rule, as evidenced by the 289 votes in the U.S. House of Representatives in favor of an amendment to block Fiscal Year 2011 funding for the implementation of this rule. One of my concerns is the use of SSNs to collect confidential taxpayer data to determine whether or not graduates are earning what the government has defined as gainful income in order for their degree program to maintain eligibility for Title IV funding.

What is the SSA doing to protect students and schools from data loss and theft? What assurances can be provided that this new system of records will not be exposed to cyber security risks, privacy risks or be subject to law enforcement or national security investigatory demands for information? In other words, has a privacy and data security impact assessment been done and, if so, what were the findings?

7) As you know identity theft is one of the fastest growing crimes in America, and one of the reasons for this is the ease of finding SSNs on unprotected documents. In many states, each foster child is issued an identity card with his or her SSN on the card and the SSN is used as the primary identifier of the child. The federal government allows for a SSN change when a foster child is going through the adoption process. A new SSN largely cleans the financial slate for these children. Is issuing a new SSN a solution for minors, such as foster youth, who have been victims of identity theft? What is the impact of issuing a new SSN?

8) When a person uses an SSN to apply for credit or open an account, what mechanisms are there for the creditor to check the legitimacy of the SSN and whether or not it belongs to a minor? Would it raise a red flag if a creditor discovered the SSN belonged to a minor? Do creditors routinely check to determine if an SSN belongs to a minor?

9) As a result of setting a limit with respect to the number of Social Security cards an individual can have, there has been an increase in the number of individuals coming into field offices asking for printouts of SSNs, also known as "Numi-Lites." What are your thoughts on charging individuals for these printouts both as way to cover costs and discourage individuals and businesses from requesting them? Is it also true that the SSA requires less proof of identity for the print outs than for a new Social Security card?

10) When it comes to enumerating foreign workers, why does the SSA not issue SSNs to temporary workers? Why are SSNs that are issued for work authorization not rescinded or suspended when the non-citizen leaves the country?

11) More children, and in fact, unborn children are having their identities stolen because thieves have figured out the algorithm SSA uses to generate the numbers. SSA is changing this now. Why can't SSA issue a new number to a child?

We would appreciate your responses to these questions by June 23, 2011. Please send your response to the attention of Kim Hildred, Staff Director, Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, B-317 Rayburn House Office Building, Washington, D.C. 20515. In addition to a hard copy, please submit an electronic copy of your response in WordPerfect or Microsoft Word format to steve.degrow@mail.house.gov.

Thank you for taking the time to answer these questions for the record. If you have any questions concerning this request, you may reach Kim at (202) 225-9263.

Sincerely,

Sam

SAM JOHNSON
Chairman

Committee on Ways and Means, Subcommittee on Social Security
Hearing on Identity Theft – April 13, 2011
Questions for the Record

1) The President's Identity Theft Task Force recommended that the Social Security Administration (SSA) become a clearinghouse for federal agencies that minimize the use of SSNs by the fourth quarter of 2007. What progress can you report on this recommendation?

The Task Force's recommendation read:

> **"Establish a Clearinghouse for Agency Practices That Minimize Use of SSNs"**
> To encourage agencies to share best practices on minimizing the use of SSNs, the Task Force recommended that we develop a clearinghouse to promote successful government initiatives in this area and to facilitate information sharing. The Task Force made the recommendation to build upon OMB's recent review of how agencies use SSNs, as well as to leverage successful efforts across the Federal government.

We implemented this recommendation in two steps. First, we formed the Social Security Number (SSN) Best Practices Collaborative, which included representatives from 36 Federal departments and agencies and met regularly in 2007 to explore, develop, and share best practices for reducing reliance on SSNs. The Collaborative formed a subcommittee chaired by the Internal Revenue Service (IRS) and comprised of agencies that handle high volumes of SSNs and personally identifiable information (PII), such as the Department of Defense, Department of Veterans Affairs, the Department of Homeland Security (DHS), the Centers for Medicare and Medicaid Services (CMS), and us.

Second, we established a clearinghouse on a bulletin board website in July 2007; over 25 agencies have registered as users to date. The clearinghouse, which remains operational and is located at www.idtheft.gov/takeaction.html, provides a forum to share materials regarding SSN use and display by Federal agencies. It highlights best practices as well as contacts for specific programs and initiatives.

2) What is SSA doing to end the practice of K-12 schools collecting students' SSNs and using them as authenticators?

We actively encourage schools and universities, as well as other entities, to reduce the unnecessary collection of SSNs by:

- Establishing a website with links to our publications, policy, frequently asked questions (FAQs), and best practices for protecting SSNs and promoting our website to State and local governments as part of our on-going educational outreach efforts;
- Coordinating with State Departments of Education and K-12 school systems to inform the education community about the potential risks of using the SSN as a student identifier;

- Encouraging State Departments of Education and K-12 school systems to implement safeguards to protect SSNs when collected; and
- Promoting the best practices States and K-12 school systems have taken to limit the use of the SSN.

We also publish pamphlets, such as *Your Social Security Number and Card*, that tell individuals not to carry their SSN card. The pamphlet also advises individuals to avoid giving out their SSN unnecessarily.

- These publications are available in our field offices and on our website.
- They also are available free of charge through the Federal Citizen Information Center in Pueblo, Colorado.

In addition, we post FAQs on our website that address identity theft and how we protect SSNs. About 50,000 people view these FAQs each month.

3) How does the SSA alert or educate cardholders on the proper protection of their SSNs? Do you inform the public on how to protect their SSNs? Does SSA conduct public outreach to institutions and businesses with respect to the display of SSNs? Does the agency provide best practices information for the handling of personal data?

We take the protection of SSNs very seriously. We keep our records confidential and disclose information only when the law permits.

We routinely inform and remind the public about ways they can protect their SSNs:

- We advise individuals to be careful about sharing their SSNs with others, even when requested;
- We encourage individuals to keep their SSN card in a safe place and not carry the card, or any document displaying their SSN, with them;
- We offer pamphlets that tell individuals not to carry the SSN card unless an employer or service provider insists on seeing it, and to avoid giving out their SSN unnecessarily (see response to question 2 for links to specific publications and the Federal Citizen Information Center);
- We post FAQs on our website that address identity theft and how we protect SSNs. About 50,000 people view these FAQs each month;
- We write stories for local newspapers across the country urging people to protect their SSN and card;
- We broadcast "Tips to Prevent Identity Theft" on our field offices' TV monitors, which explains how individuals can protect themselves from becoming identity theft victims; and,
- We partner with the Federal Trade Commission to educate the public through local seminars and public information materials.

We created a publicity campaign for the employer community entitled, "*Do You Really Need to See the Card*?" We emphasize that employers do *not* need to see the SSN card. Instead, they can quickly verify if the employee's name and SSN match our records using our free SSN

verification services. We regularly speak to the employer community, work with payroll and tax stakeholders, produce publications, and provide SSN-related information on our website.

We stress to employers and payroll professionals the importance of keeping the Social Security card and number safe and secure.

We work with the American Association of Motor Vehicle Administrators, National Association of Motor Vehicle Boards and Commissions, American Association of University Administrators, and the American Association of Collegiate Registrars and Admissions Officers to decrease and limit the use and display of the SSN on drivers' licenses or as student identifiers.

In 2010, we joined the National Cybersecurity Alliance led by DHS. This group works to increase public awareness of cybersecurity and decrease identity theft by sharing knowledge and resources among Federal agencies.

4) If someone knows their SSN has been stolen or compromised, but no actual fraud has occurred to date, can the individual apply for a new number? What guidelines does the SSA follow for when a replacement card is issued? Can the SSA help an individual protect a stolen number?

When a member of the public contacts us regarding identity theft, we take immediate action to assist them:

- We verify the accuracy of our record of the individual's reported earnings.
- We issue a replacement card with the same number if the individual's SSN card has been stolen.
- We consider assigning a new SSN if the victim requests a new SSN, and we determine the person has been harmed by misuse of the SSN.
- We provide publications such as, *Identity Theft and Your Social Security Number* and the above mentioned, *Your Social Security Number and Card*.
- We refer the individual to the FTC, which will assist the individual in placing a fraud alert with the major credit reporting bureaus (Equifax, Experian, and TransUnion), closing financial accounts, and filing necessary reports with the police.
- We refer cases of identity theft to our Office of the Inspector General (OIG). OIG will work with the United States Attorney to determine whether to prosecute the person misusing the SSN.
- We advise tax fraud victims to contact the Internal Revenue Service.

We will assign a new SSN if we determine:

- that misuse has taken place;
- there is documentation, such as a police report, of the misuse;
- the misuse was committed with criminal or harmful intent;
- the misuse has caused the individual to be personally or economically disadvantaged; and,
- the individual has been disadvantaged by the misuse within the past year.

An individual requesting a new SSN must prove age, U.S. citizenship or lawful immigration status, and identity.

An individual should consider changing his or her SSN only as a last resort. Because of the widespread use of the SSN, getting a new SSN may adversely affect a person's ability to interact with Federal agencies, State agencies, employers, schools, medical institutions, and others, as many of the individual's records may be identified under the former SSN. An individual who obtains a new SSN will have to notify banks, schools, medical institutions, etc., so that records can be properly tracked and cross-referenced. Since a new SSN can also be stolen, assigning a new SSN is not a guaranteed solution to identity theft.

We will not assign a new SSN:

- to avoid the consequences of filing for bankruptcy;
- to avoid the law or legal responsibility; or
- if no evidence exists that another person is using that number.

5) The Subcommittee is interested in removing the SSN from the Medicare card and inserting another identifying number for Medicare use, much like the military is doing with its ID cards. The SSA systems would not have to make any changes except interfacing with the Centers for Medicare and Medicare Services to identify the new number with the correct SSN already in their system. Is this the simplest way to alter the system, and if so, what are the costs and the time frames for achieving the change?

We defer to CMS with respect to the analysis of the Subcommittee's idea, costs, and timeframes. The specific effects on our systems, including costs and timeframes, would be dependent on CMS specifications to remove the SSN from the Medicare card.

We appreciate the importance of addressing potential identity theft and fraud issues. Nevertheless, we must balance the benefits of removing the SSN from the Medicare card against the additional resources required to do so. We expect that any proposal would require changes to our systems and would increase visits to our field offices and calls to our toll-free number. Congress cut $1 billion from our fiscal year 2011 budget request, and we are concerned about our resource ability to implement changes.

6) As you may know, the Department of Education recently proposed a rule known as the "gainful employment" ruling that would limit the use of Title IV funding at proprietary, or for-profit, colleges. This rule would employ a formula based on a student's debt and income to determine whether students at these schools meet the Department's definition of holding gainful employment after graduation. Many Members of Congress have concerns with this rule, as evidenced by the 289 votes in the U.S. House of Representatives in favor of an amendment to block Fiscal Year 2011 funding for the implementation of this rule. One of my concerns is the use of SSNs to collect confidential taxpayer date to determine whether or not graduates are earning what the government has defined as gainful income in order for their degree program to maintain eligibility for Title IV funding.

What is the SSA doing to protect students and schools from data loss and theft? What assurances can be provided that this new system of records will not be exposed to cyber security risks, privacy risks or be subject to law enforcement or national security investigatory demands for information? In other words, has a privacy and data security impact assessment been done and, if so, what were the findings?

The IRS owns tax return data. Our authority to use and share tax return data for disclosure purposes is subject to section 6103 of the *Internal Revenue Code* (IRC).

We will provide strictly statistical aggregate data, including mean and median calculations, to the Department of Education (DOE). These data will not contain any information on individual taxpayers, and we will not identify any taxpayer, either directly or indirectly. As such, the data we will provide is not tax return information protected by section 6103 and our use will fully comply with the requirements of the IRC. The *E-Government Act of 2002* requires agencies to conduct privacy impact assessments (PIA) for new electronic information systems and collections containing PII and make them publicly available. Since we are not collecting or sharing new PII in this instance, we do not need to conduct a PIA.

We discussed our proposal for providing aggregate data to DOE with IRS Counsel before preparing the reimbursable agreement. We plan to use the taxpayer identifying information we receive from DOE to match our records and perform an electronic data exchange in accordance with all applicable privacy and security laws and regulations. Once we draft the data exchange agreement, we will share the agreement with IRS Counsel to ensure that we comply with all provisions of the IRC.

7) As you know identity theft is one of the fastest growing crimes in America, and one of the reasons for this is the ease of finding SSNs on unprotected documents. In many states, each foster child is issued an identity card with his or her SSN on the card and the SSN is used as the primary identifier of the child. The federal government allows for a SSN change when a foster child is going through the adoption process. A new SSN largely cleans the financial slate for these children. Is issuing a new SSN a solution for minors, such as foster youth, who have been victims of identity theft? What is the impact of issuing a new SSN?

With respect to identity theft, our treatment of minors is identical to our treatment of adults. Please see our answer to question 4 above.

8) When a person uses an SSN to apply for credit or open an account, what mechanisms are there for the creditor to check the legitimacy of the SSN and whether or not it belongs to a minor? Would it raise a red flag if a creditor discovered the SSN belonged to a minor? Do creditors routinely check to determine if an SSN belongs to a minor?

We offer a fee and consent-based verification service, Consent Based SSN Verification (CBSV), which provides instant, automated verification to enrolled private companies. Using CBSV,

participating companies can confirm that a name, SSN, and date of birth match information in our records.

Because this is a consent-based service, a company must have written permission from the number-holder to conduct the match. We charge a fee to cover the costs of this service because it does not relate to the administration of our programs. Of the 153 companies currently enrolled, 72 companies have used CBSV since 2008. Based on the information contained in each company's profile, 66 companies identified themselves as "Mortgage/Banking Services" as the reason for using CBSV.

Regarding the issuance of credit to minors, we do not have any oversight of the financial industry. The Federal Reserve Board, the Consumer Financial Protection Bureau, and other agencies responsible for the banking industry have oversight in this matter.

9) As a result of setting a limit with respect to the number of Social Security cards an individual can have, there has been an increase in the number of individuals coming into field offices asking for printouts of SSNs, also known as "Numi-Lites." What are your thoughts on charging individuals for these printouts both as a way to cover costs and discourage individuals and businesses from requesting them? Is it also true that the SSA requires less proof of identity for the print outs than for a new Social Security card?

The Freedom of Information Act requires us to provide copies of our records to number-holders upon request. The main reason individuals request printouts is because an employer has requested such a document. We may consider charging a fee for the printout in the future, but current statutory language does not allow us to charge a fee for this service.

We require an individual to submit certain documents as proof of identity for an SSN card. An acceptable document must be current (not expired) and show the person's name, identifying information, and preferably a recent photograph. We will not issue an original SSN card without proper evidence of identity, age, and citizenship. In the case of noncitizens, we also require proof of work authorization.

When an individual requests a "NUMI-Lite" or any other information, the requester must provide the SSN and establish his or her identity by supplying certain identifying information. We compare the information provided to us with information in our records. These evidence requirements provide sufficient proof to release information to the individual.

10) When it comes to enumerating foreign workers, why does the SSA not issue SSNs to temporary workers? Why are SSNs that are issued for work authorization not rescinded or suspended when the non-citizen leaves the country?

The *Social Security Act*[1] requires us to issue SSNs to aliens with work authorization, regardless of the duration of the work authority. The SSN cards we issue to foreign workers with

[1] Section 205(c)(2)(B)(i)(I).

temporary work authority bear the restrictive legend "valid for work with DHS authorization" on the face of the card.

We issue SSNs in order to keep track of workers' earnings and to correctly calculate and pay benefits. Under totalization agreements, temporary workers may become eligible for benefits based, in part, on earnings in the U.S. long after they have left the U.S., just as U.S. citizens may receive benefits based, in part, on work they performed outside the U.S.

The SSN does not provide work authorization, only documents issued by DHS can provide such authority to a non-citizen. DHS can extend work authority for a non-citizen and DHS determines when a non-citizen must leave the country.

11) More children, and in fact, unborn children are having their identities stolen because thieves have figured out the algorithm SSA uses to generate the numbers. SSA is changing this now. Why can't SSA issue a new number to a child?

Please see our answer to question 4 above with respect to issuing a new SSN to a child. Our treatment of children is identical to our treatment of adults.

As you note, we are randomizing the SSN assignment process. Through randomization, we can include previously excluded area numbers and thus increase the pool of SSNs available for assignment from 288 million to 422 million. We also believe randomization will impede reconstructing an individual's SSN.

SOCIAL SECURITY
The Deputy Commissioner

SEP 16 2011

The Honorable Sam Johnson
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your letter of August 1, 2011 requesting additional information in order to complete the record for the June 14, 2011 hearing on Social Security's payment accuracy. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

I am sending a similar letter to Chairman Boustany.

Sincerely,

Carolyn W. Colvin

Carolyn W. Colvin

Enclosure

Committee on Ways and Means

Subcommittees on Oversight and Social Security

Hearing on Payment Accuracy – June 14, 2011

Questions for the Record

1. **In 2004, the U.S. Government Accountability Office recommended that the Social Security Administration (SSA) use the National Directory of New Hires, which the agency uses for Supplemental Security Income (SSI) cases to alert the agency to wages earned by those receiving benefits with an estimated return of 40 percent on each dollar invested. Why have you not implemented this recommendation and why does the agency contend it is not cost effective?**

   We prioritize the use of our limited administrative resources to focus on those program integrity activities with the highest return on investment (ROI). In 2010, we conducted a study that matched a sample of title II disability beneficiaries with the Office of Child Support Enforcement's National Directory of New Hires quarterly wage file to determine whether that matching operation could help curb improper payments in the disability insurance program. This data match is much less cost effective than continuing disability reviews, which have an ROI of $10 for every $1 spent, or SSI redeterminations, with an ROI of $7 for every $1 spent. However, we will look again at the viability of a potential data match.

2. **Cooperative Disability Investigation (CDI) Units often investigate suspect claims to determine if the disability applicant is in fact disabled. When someone is caught applying for benefits despite having no actual disability, are any measures taken against them for trying to cheat the system? Is there any kind of penalty for fraudulent applications and if not, should there be?**

   Sections 208 and 1632 of the Social Security Act (Act) provides for a wide range of penalties against individuals who make false statements, or who misrepresent or omit material facts used in determining eligibility for, or the amount of, Social Security or SSI benefits. Any time we suspect fraud, we refer the case to our Office of the Inspector General (OIG).

   OIG can work with the Department of Justice to pursue criminal penalties, as appropriate. Any false statement in an attempt to obtain benefits not due is punishable by fine, imprisonment, or both, under the Act and other Federal statutes. For example, individuals convicted of violating section 208 or 1632 of the Act face a fine of up to $250,000 per offense or a prison term of up to five years, or both. Individuals convicted of violating 18 U.S.C. 641 face a prison term of up to 10 years or a fine of up to $250,000, or both. Individuals convicted of violating 18 U.S.C. 1001 face a prison term of up to five years or a fine of up to $250,000, or both.

Our CDI program works to obtain sufficient evidence to resolve issues of fraud related to initial. Where the CDI unit obtains evidence of fraud prior to our putting a claimant onto the disability rolls, the claimant generally will not be criminally prosecuted because the program suffered no monetary loss. We will, though, deny a claim based on the CDI findings. This fiscal year, the CDI units found evidence of fraud in 2,491, or 91.6 percent, of the cases they closed. We denied the claim in all of these cases.

We can also impose civil monetary penalties. Section 1129 of the Act allows civil monetary penalties of up to $5,000 for each false statement, misrepresentation, conversion, or omission of material facts used in determining eligibility for, or the amount of, benefits. In addition, OIG can impose an assessment of up to twice the amount of benefits paid because of a false statement, misrepresentation, or withholding of a material fact. OIG considers CDI cases, even those with no monetary loss, for civil monetary penalty action. In fiscal year (FY) 2010, OIG initiated 117 such cases and successfully resolved 87 through a settlement agreement, default, or decision by the Department of Health and Human Services Departmental Appeals Board. OIG's actions resulted in penalties and assessments imposed of over $3.9 million.

Finally, we can impose administrative sanctions. Under section 1129A of the Act, we can impose such sanctions on anyone who makes a false statement or misrepresents a material fact, or who omits material facts used in determining eligibility to, or the amount of, benefits. In FY 2010, we assessed 542 administrative sanctions.

The applicable sanctions are:

- For the first offense, loss of benefits for 6 consecutive months;
- For the second offense, loss of benefits for 12 consecutive months; and,
- For subsequent offenses, loss of benefits for 24 consecutive months.

3. **Your Access to Financial Institutions (AFI) automated program has been successful in verifying SSI eligibility. The automated phone reporting system apparently works well for updating recipients' income and asset eligibility. But since the Agency is still unable to keep current with SSI redetermination work, what other strategies are you exploring? Where can we introduce additional automation to relieve pressure on those processing these workloads?**

Section 1611(c)(1) of the Act provides the Commissioner of Social Security with the discretion to determine how often to perform SSI redeterminations.. We target the number of redeterminations we conduct each year based on available resources, and for at least the last four fiscal years, we completed more redeterminations than we estimated.

Underscoring our sustained commitment to reducing improper payments in the SSI program, we have steadily increased our SSI redeterminations in the recent past from just over 1 million completed in FY 2007 to 2,422,000 scheduled for completion in FY 2011.

To improve the efficiency and effectiveness of our SSI redeterminations, we continually work to enhance our predictive statistical model that selects SSI redeterminations each year based on the dollar amount of likely SSI overpayment. Beginning in FY 2012, our predictive model will improve our ability to capture the effect of complex living arrangement changes on SSI program payments.

In addition to improving our analytical modeling, we are piloting a program to investigate non-home real property informational leads via several web-based commercial sources. The purpose of this pilot is to determine the accuracy and reliability of property information available on the leading commercial websites and determine the cost-effectiveness of using this information to identify undisclosed property for SSI beneficiaries and applicants. We will use the study results to develop a methodology to reduce improper SSI payments caused by undisclosed property ownership.

4. **When an SSI child is not reviewed at age 18, he or she may continue to receive benefits further into adulthood, perhaps up to age 22. Are you concerned this leads to adult dependency on the program?**

   Our system selects for review over 95 percent of age-18 redeterminations by the beneficiary's 18th birthday. We select the remaining cases within 6 months of the beneficiary's birthday.

   We complete 80 percent of age-18 redeterminations by the beneficiary's 19th birthday and 96 percent by the beneficiary's 20th birthday. Because we complete the majority of age-18 redeterminations by the beneficiary's 20th birthday, we do not believe the timing of these reviews raises concerns about adult dependency on the program.

   If we find the individual no longer qualifies for benefits at the age-18 redetermination, the law requires us to continue to pay benefits if : 1) the individual is participating in an appropriate program of vocational rehabilitation or similar service, and 2) we determine that participation will increase the likelihood that the individual will be permanently removed from the disability rolls. This temporary continuation of benefits is designed to decrease dependence on SSI in the long term.

5. **One of the ways the SSA completes medical Continuing Disability Reviews (CDRs) is by sending beneficiaries questionnaires asking about their medical treatment, work activities, and disabilities generally. Can you tell us more about the role these mailers play in preventing improper Social Security payments and how they work?**

   The CDR profiling process allows us to identify beneficiaries with a low likelihood of medical improvement and to use a streamlined mailer process to complete the CDR. This allows us to focus scarce resources on those that provide the highest likelihood of medical improvement.

   We first profile every disability case to identify those with a higher likelihood of medical improvement. We send those cases to a State disability determination service (DDS) for a full medical review. For the remaining cases with lower likelihoods of medical

improvement, we send a mailer to obtain more information, which we evaluate to determine if there is any indication of medical improvement. If there is, we send the case to the DDS for a full medical review.

6. **In the hearing during questioning on work CDRs, you said you instructed your agency to have reviews done within 30 days from the time the person returns to work. Please give us more information on that plan. How soon should the SSA start to see results? What management controls and goals have you set? How is progress measured?**

   The 30-day goal applies only to work reports we receive from beneficiaries. It does not apply to work CDRs we initiate due to our match with IRS or reports from any other source. Our goal is to screen beneficiary work reports within 30 days to determine if the work activity is likely to affect benefit payments or entitlement. If the work activity will affect benefits or entitlement, we assign the case for review, with a goal of completing the case review and processing within 270 days. We are making progress with this workload. To continue to address this workload more efficiently, we are:

   - Streamlining policies by:
     - Revising our work activity reports;
     - Planning to eliminate the signature requirement on the work activity reports; and,
     - Planning to minimize documentation for work activity that is obviously not substantial gainful activity; and
   - Shifting work to offices with more capacity to conduct the CDR.

7. **What is the percentage of SSI age-18 redeterminations completed on time? What is the average time frame? Should these also be subject to the 30-day goal of starting the redeterminations in that time frame? Should all SSI redeterminations be subject to the 30-day starting goal?**

   We release for review over 95 percent of age-18 redeterminations by the beneficiary's 18th birthday. Our goal is to complete those redeterminations by the beneficiary's 20th birthday.

   Age-18 redeterminations are our top priority medical CDR workload. We do not believe a goal of initiating these CDRs within 30 days would improve performance, as having a goal does not mean that we have the resources to achieve it.

   With respect to whether non-medical SSI redeterminations should be subject to a 30-day goal, we do not believe that this workload lends itself to such a goal for two reasons:

   - We use a selection process that selects most of the redeterminations at the beginning of the fiscal year, allowing field offices the flexibility to balance this workload with their other priorities throughout the fiscal year; and

- Because of evidentiary requirements, we have to give the beneficiary at least 30 days to provide us with the necessary proofs *after* we request such proofs.

For every year since FY 2007, we have exceeded our targets for completing SSI non-medical redeterminations.

8. **As CDRs and SSI redeterminations are important to program integrity, what number of medical and work CDRs would the SSA need to do over a ten-year period to reduce the backlog and stay current? What number of SSI redeterminations need to be done each year to catch up with the present workload and then stay current?**

"Staying current" has different meanings for the three specific types of program integrity workloads mentioned (medical CDRs, work CDRs, and SSI non-medical redeterminations). Let me first summarize the response to the question.

- Medical CDRS -- We began FY 2011 with a backlog of 1.4 million medical CDRs. The Budget Control Act specifies amounts to be appropriated for future program integrity work. If we receive those amounts, we would be able to catch up on title II CDRs by 2016 and on CDRs for SSI disabled children a few years later. We would be able to complete almost 8 million full medical reviews over the next 10 years. This funding, however, is insufficient to permit us to catch up on SSI disabled adult medical CDRs.

- Work CDRs -- We process about 250,000 to 300,000 of these cases annually.

- SSI Redeterminations -- We determine the number of redeterminations we process each year based on available resources. Historically, we complete all redeterminations we select each year. If we receive the program integrity funding specified in the Budget Control Act of 2011, we project that we can complete roughly 2.6 million non-medical redeterminations per year over the next 10 years.

To facilitate complete understanding of the differences in these workloads and why "staying current" has different meanings, I am providing more detail.

Medical CDRs—Of the three program integrity workloads, medical CDRs are the only one where the law specifies a timeframe for completing the work. The specified timeframe varies by type of benefit, as well as by the degree of impairment. In general, under the title II disability program, we are required to review disabled beneficiaries' continued entitlement once every three years. The review can be scheduled sooner or later than the three-year period depending on our evaluation of individual cases and when we expect medical improvement to occur. Similar timeframes apply to SSI disabled adults. A different framework applies to SSI disabled children and is based on their disability and age, including a requirement that all SSI disabled children be reassessed using the adult disability standard upon attainment of age 18. We must review low birth weight babies within one year and children with non-permanent impairments once every three years.

Using the requirements specified in the law for frequency of reviews, we currently have a significant number of reviews that are overdue. This situation has existed since 1996 (except for a very brief period in 2002 when we caught up on medical CDRs using special funding that Congress provided in the Contract with America Advancement Act of 1996). Since 2002, funding appropriated by Congress in the annual budget process provided significantly fewer resources than we needed to stay current with all medical CDRs. Similar to that earlier special funding, the Budget Control Act of 2011 specifies amounts to be appropriated for future program integrity work. If we receive those amounts, we would be able to catch up on Title II CDRs by 2016 and on CDRs for SSI disabled children a few years later. We would complete almost 8 million full medical reviews over that period. The funding, however, is insufficient to permit us to catch up on SSI disabled adult medical CDRs.

Work CDRs—This workload, while equally important for maintaining program integrity, is very different from the other two program integrity workloads. A work CDR is triggered when a title II disabled beneficiary either reports his or her own work activity or when we discover work activity through data matching with Internal Revenue Service earnings reports or other sources of information on earnings. We process 250,000 to 300,000 of these cases annually. Not all work activity would cause a change in benefits owed, because the work-incentive provisions under title II permit some level of work during a trial work period or extended period of eligibility with no effect on benefits. While we investigate all reported work, not all work CDRs result in trust fund savings. This workload is subject to year-to-year fluctuations corresponding to beneficiary work activity. Our goal is to complete this work as quickly as possible, but resource limitations play a role in determining how timely we complete the work CDRs.

SSI non-medical redeterminations—The Social Security Act does not specify timeframes for completing this type of review, but authorizes the Commissioner to determine the frequency with which such reviews should be completed. Because we do not have the resources to conduct a yearly redetermination of every SSI beneficiary's continued eligibility, we target those beneficiaries who are most likely to have a change in circumstances that affects their monthly payment amount. Using a statistical model, we score each SSI beneficiary to predict the likelihood of an overpayment occurring. We then review the highest-scored SSI beneficiaries and, subject to available administrative funding, schedule redeterminations that will develop all of the eligibility factors for those selected cases. The number of targeted reviews we can complete in a given fiscal year depends upon the amount appropriated to complete such work in a given year.

If we receive the program integrity funding specified in the Budget Control Act of 2011, we project that we can complete roughly 2.6 million non-medical redeterminations per year over the next 10 years.

9. **The ratio of savings to investment declines as more integrity work is completed. How does that ratio decline for each of the three categories (medical CDRs, SSI redeterminations, work CDRs)? Does the amount of savings in the Medicare and Medicaid programs decline also? How much?**
As with the response to question #8 above, the answer to this question varies depending on the type of workload:

Medical CDRs—As required by law, we have reported to Congress every year since 1996 on the ROI from conducting medical CDRs. As we reduced the backlog of overdue CDRs over the period 1996-2002, the estimated ROI from these annual cohorts declined from about $12 saved for every $1 spent to about $9 saved for every $1 spent.[1] After FY 2002, funding for CDRs was insufficient to stay current with the CDRs that were due. To make the best use of available funding, we limited the number of reviews by selecting cases where we expected the largest ROI. Accordingly, the ratio of benefits to cost since 2002 has grown again to over $10 to $1. We estimate that once we achieve currency in the medical CDR workload, our ROI will be $9 for each $1 spent.

SSI non-medical redeterminations—In the report recently submitted to Congress, we stated that the ratio of net lifetime Federal benefit savings from scheduled redeterminations to the cost for doing those redeterminations was $7.5 to $1.[1] If you add in the unscheduled redeterminations, which most often result in uncovering an underpayment, that ratio is lowered to slightly less than a$6 to $1.[2]

Work CDRs—While we have looked at small pieces of the work CDR process individually, we have not conducted the comprehensive review of process that would be required to determine an overall ROI for this work and do not currently have the management information we would need to make that determination. Estimating ROI for work CDRs would be a very complex and labor-intensive undertaking. There are several reasons:

- Unlike medical CDRs, work CDRs are not scheduled. Instead, we initiate a work CDR based on our analysis of a report advising us that a beneficiary has returned to work.
- The Social Security Act includes a wide variety of complex work incentive provisions, including the trial work period and the extended period of eligibility.
- Beneficiary responses to these work incentive provisions vary widely from case to case.

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[1] Includes savings accruing to Medicare and Medicaid.

[2] We select and conduct scheduled redeterminations at periodic intervals that vary depending on the likelihood of payment error. We conduct unscheduled redeterminations when a beneficiary reports a change in circumstances that may affect eligibility and payment amount.

10. Seniors in some districts feel they have received misleading information from the Social Security help line. What is the agency doing to ensure that information provided on the help line is accurate and complete?

We make every effort to deliver the best possible public service via our National 800 Number network. Through workload forecasts, resource planning, detailed management information analysis, and real-time network monitoring, we continually improve the quality and accuracy of all automated and agent services.

We provide interactive video training broadcasts for 800 Number agents twice a month to keep employees abreast of new procedures. When we identify deficiencies, implement enhancements to our computer systems, or implement new legislation, we provide the necessary tools, including in-service training and mentoring, to improve our agents' performance.

Our National 800 Number network also utilizes the web-based Customer Help and Information Program, a decision support tool that prompts the 800 Number agent to provide consistent responses regarding our programs, ask appropriate questions, and process actions correctly.

We also conduct annual telephone service evaluations that measure the accuracy of our National 800 Number service. For FY 2009 (most recent data available), the accuracy rate for information and actions our agents took on issues affecting eligibility or payment of benefits was 95.8 percent.

11. One of the concerns with CDR mailers is that the results are based on self-reporting and are rarely verified. What safeguards are in place to protect against dishonest answers by those that would cheat the programs?

To develop the CDR statistical models, we analyzed the results of millions of full medical reviews over the course of many years to identify indicators of medical improvement. We consulted with private contractors to verify the statistical validity of the predictive models. In addition, an independent auditor, as a part of our financial statement audit, audits the mailer process each year.

We send the mailer to beneficiaries who have the least likelihood of medical improvement, based upon our analysis of past disability cases involving similar impairments. We also conduct full medical reviews on a random sample of cases, regardless of the response, to determine the effectiveness and integrity of the identification process. Our mailer process allows us to screen out unproductive CDRs and concentrate our resources on full medical reviews of those beneficiaries most likely to have medical improvement.

12. Are there specific regions where Social Security fraud is greater than other places, and what is the agency doing about this?

In examining allegations received and investigations conducted by OIG's 10 field divisions, we cannot specify regions where fraud is more prevalent than in other regions. Factors contributing to the number of reported fraud allegations and investigations conducted in a given region may include, but are not limited to:

- The number of OIG offices and size of the geographic area of responsibility of each OIG field division;
- The number of CDI units within a particular region; and
- The number of SSA field offices and DDS offices within a particular region.

We work closely with OIG to defend our programs against fraud and abuse. For example, we work with OIG on the CDI program, which combines the skills and specialized knowledge of SSA, OIG, DDS, and State or local law enforcement personnel to combat disability fraud.

Currently, CDI units are strategically located in 23 cities throughout the country, with plans to open two additional units by the end of FY 2011. The CDI program has been in operation for 14 years, resulting in about $1.8 billion in projected SSA program savings. We pursue CDI unit expansion when we have appropriate available funding and staffing.

OIG becomes aware of Social Security fraud through reports from various sources, including SSA, other law enforcement agencies, government agencies, and private citizens. OIG receives fraud allegations through several channels, including an electronic referral process from SSA employees; calls, letters, and emails to our OIG hotline; and direct referrals to our OIG offices located throughout the country. From those allegations, OIG reviews and develops information, and initiates investigations as it seems appropriate.

To identify fraud proactively, OIG's Strategic Research and Analysis Division tracks fraud trends and identifies possible cases of specific types of fraud, referring those cases to SSA or OIG's criminal investigators for further development.

13. To become current and stay current on both SSI and all CDR work will require more funding for SSA. However, given the long-term federal budget situation and the need to keep federal personnel costs in check, what staffing strategies should SSA pursue to ensure integrity work is completed without significant hiring increases?

While we continue to look for ways to become more efficient, our program integrity work is labor-intensive and requires a high level of expertise. We complete this work most efficiently when we assign it to experienced staff. The same employees who do program integrity work handle many other workloads, including claims. These individuals are also best suited to provide training and mentoring to develop additional experts.

Other core work will be delayed if we have to complete more program integrity work without additional funding. The administrative cost of our program integrity reviews is paid for many times over through the billions of dollars in program savings.

We already use predictive modeling in the SSI redetermination process to target cases that are likely to have improper payments. Each year, we identify cases for review based on the likelihood of error and prioritize the reviews based on allocated funds.

In FY 2011, we began to implement an electronic CDR process, which increases our productivity and accuracy compared to the paper-based process. In FY 2012, as part of the electronic CDR process, we plan to implement an electronic CDR record and other enhancements that will make mailing CDR packages to DDSs obsolete.

14. What are your recommendations to reduce overpayments?

There are several proposals in the President's FY 2012 budget that would help us reduce improper payments.

One proposal would provide us with new demonstration authority, under which we would conduct the Work Incentive Simplification Pilot. This pilot has the potential to reduce improper payments by replacing our complex title II disability return-to-work rules with a clear, simple, work review process. Simplifying the title II disability work rules will also allow us to take advantage of more automated processes for wage reporting and posting. The combination of better reporting, increased beneficiary understanding, and simpler case processing should help us reduce improper payments.

Another proposal would require State and local governments to identify and report to us when a pension is paid to a former employee based on work that was not covered by Social Security. This information would improve our administration of the Windfall Elimination and Government Pension Offset provisions by allowing us to reduce benefit payments.

A third proposal would require all entities that pay workers' compensation and public disability benefits to provide us with information needed to impose offset of title II disability benefits and reduce SSI payments.

In addition to legislation, we are exploring several initiatives to ensure accurate reporting of beneficiaries' earnings. The first initiative would increase the use of the existing SSI telephone wage reporting process by SSI representative payees. We are also considering extending telephone wage reporting to title II disability beneficiaries and establishing a website for title II and title XVI disability beneficiaries to report their wages.

We are also expanding upon our successful AFI initiative. When fully implemented, it will provide an estimated $900 million in lifetime program savings per year, equivalent to $20 of savings for every $1 of administrative expense.

Building on our AFI success, we are exploring the use of commercial databases to help us identify undisclosed non-home real property held by SSI applicants and beneficiaries.

This automated approach could help find unreported assets and improve the accuracy and integrity of the SSI program.

Congress of the United States
House of Representatives
COMMITTEE ON WAYS AND MEANS
WASHINGTON, DC 20515

SUBCOMMITTEE ON SOCIAL SECURITY

August 26, 2011

The Honorable Michael J. Astrue
Commissioner of Social Security
Social Security Administration
6401 Security Boulevard
Woodlawn, MD 21207

Dear Commissioner Astrue:

Thank you for testifying at the Committee on Ways and Means Subcommittee on Social Security and the Committee on the Judiciary Subcommittee on Courts, Commercial and Administrative Laws' July 11, 2011, joint hearing on the role of Social Security Administrative Law Judges. In order to complete the record of the hearing, please respond to the following questions by Friday, September 9, 2011:

1. As a means of helping to reduce hearing backlogs and cope with increasing applications, has the Agency ever considered contracting with outside practicing attorneys or retired Administrative Law Judges (ALJs) to handle additional hearings? Please provide details as to how this option has worked if previously pursued, whether you are exploring such an option, and if not, why not?

2. You testified that as a result of an FY 2011 appropriation at the FY 2010 level, you had to suspend your plans to open eight new hearing offices. During your tenure, you have opened several National Hearing Centers (NHCs) for the express purpose of transferring cases from heavily backlogged offices in an effort to balance workloads. The NHCs have been a successful component of your backlog reduction plan. Why do you need to build more brick and mortar hearing offices when the electronic folder and the NHC are working so efficiently?

3. Social Security has received high marks in an Administrative Conference of the United States (ACUS) study on its use of video hearings. In fact, on June 17th, ACUS adopted a final recommendation strongly encouraging the use of video hearings by federal government agencies with high volume caseloads as a means of reducing caseload backlogs and conducting more efficient adjudications. How has the Agency's use of video conferencing improved public service? Video teleconference hearings sound as though they are a highly beneficial way to accommodate claimants, ensure due process, and manage taxpayer funds efficiently and effectively. What can Congress do to further support the use of video conferencing?

4. You testified that 118 union ALJs have reduced time because of their union responsibilities and are among those ALJs who do not handle 500 cases. Please identify for the record the names and number of dispositions of these 118 ALJs. What do these ALJs spend their time on? What is the size of the ALJ bargaining unit compared to the size of other bargaining units? Are they required to obtain prior approval for these activities? Are their duties and the time spent on them comparable to the time spent by other union officials? Also, under their collective bargaining agreement, judges can work from home. Why is this? What work gets done from home and how are they held accountable?

5. Is the ALJ hearing open to the public? Why or why not?

6. You testified that 75 to 80 percent of claimants use attorneys or non-attorneys and that their fees are a percentage of the back payment due the claimant. Such payments are made under previously-approved fee agreements. Claimant representatives can also be paid by submitting fee petitions to the Agency after an approval has been made. Please indicate the percentage of representative fees paid under fee petition in FY 2010, and the range of dollar amounts of such fees. Please also identify the officials who have delegated authority to approve those fee petitions and the dollar amount of those delegations.

7. Those appealing their claims may have an attorney or non-attorney representing them. How much did claimants pay their representatives last year? What are the tools you have to ensure representatives are helping claims move through the process as opposed to hindering the process? For example, are they required to file appeals and supporting documents electronically and on a timely basis?

8. Please provide a description of each step of the disability determination appeals process and for each step please clarify whether it is specifically required by statute or regulation.

9. You testified that you would like to see improved communication with and have more input to the Office of Personnel Management (OPM) about ALJ hiring. What specific input would you like with OPM regarding the ALJ exam and register?

10. How much does it cost the taxpayer, on average, to fire a judge, including their salary?

11. You testified that Congress should consider changing current law to suspend an ALJ's salary after the first level of determination. Could you please clarify your thoughts on this issue and specify what you are referring to by the "first level of determination"?

12. Currently, an ALJ is hired directly into a career status. What do you think about a tracked approach to the ALJ process, with set benchmarks that must be met before an ALJ is on the career track, like a professor earning tenure?

13. The recent Wall Street Journal article about the judge in West Virginia raises a number of questions. From all accounts, this ALJ has had high approvals and high production numbers for some years, so how did he escape management's notice for so long? Why did it take a Wall Street Journal article for the agency to begin to investigate?

14. In 2010 there were 54 judges awarding benefits in over 85 percent of their cases. What can you do to manage extreme differences between approvals and denials? What if you suspect a judge's award rate means rubberstamping approvals? What do you do and how can you be sure that these outliers aren't awarding benefits to people who aren't really disabled? What effect do outliers have on the rest of the corps and the public's perception about the fundamental fairness of the system?

15. You mention a recent initiative to look at a statistical sampling of ALJ awards to identify patterns of disconnect with the law. Please give the specifics of this initiative and identify who is in charge of the sampling and the analysis?

16. A case changes with each appeal since the record remains open, meaning new medical evidence or other information may continue to be added. The open record concept is different from other Administrative Procedures Act (APA) proceedings. Would you talk about the pros and cons of an open record and how you have studied these issues since you've become Commissioner? What happens if new evidence comes in after the ALJ has made a decision? Does the claimant get a new hearing? What are the costs, in particular at the hearing and Appeals Council levels, of keeping the record open?

17. What does it cost to process an initial decision by a State Disability Determination Service that is 100 percent federally funded? What does it cost to process a request for a hearing? What accounts for the difference and what actions have been taken to bring down hearing costs while still fully protecting the due process rights of claimants?

18. According to the Wall Street Journal article, Judge Daugherty was assigning himself all of the cases from one particular lawyer. Isn't this a breach of policy, and how was this allowed to happen?

19. In your written testimony you cite peer review as one way to enhance ALJ performance management. How would you implement a peer review program at SSA?

20. If SSA had been unable to draw down reserves in its information technology carryover fund in order to compensate for funding shortfalls in FY 2011, would the agency have had to resort to staff furloughs?

21. Please provide the number of ALJs who, in FY 2010, approved cases at a rate that was 25 percentage points higher than the national average approval rate, and how many ALJs approved cases at a rate that was 25 percentage points lower than the national average approval rate (considering approvals as a fraction of all dispositions).

22. You testified that because disability decisions are made under the Social Security Act and not the APA, there is some question about whether the Agency could review ALJ decision-making. We take this to mean that while the decision-maker in APA proceedings was intended to be independent, the decision-maker in SSA proceedings, who is making decisions for the Commissioner, may have some level of accountability to the Agency under the Social Security Act. Is that true? What analysis have you made about what the Social Security Act would require? How do those requirements exist with respect to the APA? Based on the Social Security Act's requirements, will you develop management parameters for your ALJs?

Please send your response to the attention of Kim Hildred, Staff Director, Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, B-317 Rayburn House Office Building, Washington, D.C. 20515. In addition to a hard copy, please submit an electronic copy of your response in Microsoft Word format to jessica.cameron@mail.house.gov.

Thank you for taking the time to answer these questions for the record. If you have any questions concerning this request, you may reach Kim at (202) 225-9263.

Sincerely,

Sam Johnson

SAM JOHNSON
Chairman

Questions for the Record
For the July 11, 2011 Hearing
On SSA Administrative Law Judges

1. **As a means of helping to reduce hearing backlogs and cope with increasing applications, has the Agency ever considered contracting with outside practicing attorneys or retired Administrative Law Judges (ALJs) to handle additional hearings? Please provide details as to how this option has worked if previously pursued, whether you are exploring such an option, and if not, why not?**

   For the past 20 years, we have re-hired retired ALJs through the Senior ALJ program in our ongoing effort to reduce the backlog of pending disability hearings. To ensure that we are reemploying only productive ALJs, we regularly monitor their workloads. We currently employ 20 Senior ALJs and regularly look for additional productive retired ALJs to re-hire.

   The Office of Personnel Management (OPM) administers the Senior ALJ program. When we decide to hire a Senior ALJ, OPM provides us with the names of retired ALJs on the Senior Master List. Senior ALJs receive temporary appointments (not-to-exceed one year), which we can extend.

   We would need legislative authority to contract with outside practicing attorneys to conduct our hearings. The Social Security Act (Act) allows only "officers and employees" of the agency to render decisions on behalf of the Commissioner of Social Security. 42 U.S.C. § 902(a)(7). Moreover, our programs are very complex, and we believe that unless we provided significant, resource-intensive training, practicing attorneys would not be qualified to adjudicate our claims.

2. **You testified that as a result of an FY 2011 appropriation at the FY 2010 level, you had to suspend your plans to open eight new hearing offices. During your tenure, you have opened several National Hearing Centers (NHCs) for the express purpose of transferring cases from heavily backlogged offices in an effort to balance workloads. The NHCs have been a successful component of your backlog reduction plan. Why do you need to build more brick and mortar hearing offices when the electronic folder and the NHC are working so efficiently?**

   The NHCs have been a tremendous success and continue to be an integral part of our backlog reduction plan. However, to continue to serve our claimants and the American public as efficiently and effectively as possible, we need brick and mortar hearing offices in addition to NHCs.

   As I testified, we received 130,000 more hearing requests in fiscal year (FY) 2010 than we received in 2008, and we expect to receive 114,000 more requests in FY 2011 than we did in FY 2010. Despite these increased numbers, we have been able to reduce the time for issuing a hearing decision from an average of 532 days in February 2008 to 345 days

in August 2011. We have been able to achieve these goals while facing the challenge of an increased workload because we have opened and staffed several brick and mortar offices in the past few years.

Under our regulations, claimants generally have the right to decline a video hearing and request an in-person hearing. Therefore, despite the NHCs' success, we still need brick and mortar offices where claimants can have an in-person hearing. In-person hearings are also more efficient for those cases with paper claims folders, which are more difficult to transfer between offices.

3. **Social Security has received high marks in an Administrative Conference of the United States (ACUS) study on its use of video hearings. In fact, on June 17th, ACUS adopted a final recommendation strongly encouraging the use of video hearings by federal government agencies with high volume caseloads as a means of reducing caseload backlogs and conducting more efficient adjudications. How has the Agency's use of video conferencing improved public service? Video teleconference hearings sound as though they are a highly beneficial way to accommodate claimants, ensure due process, and manage taxpayer funds efficiently and effectively. What can Congress do to further support the use of video conferencing?**

Video teleconferencing has allowed us to schedule and handle more hearings, reducing the time claimants have to wait for both a hearing and a hearing decision. Using video, we can provide better service to claimants in remote areas that are not located near a hearing office by allowing these claimants to have their hearings closer to home. Additionally, use of video teleconferencing significantly reduces our costs and travel time for ALJs and diminishes concerns about holding hearings in unsecured locations. Video teleconferencing allows us to transfer electronic cases more easily between hearing offices, thereby increasing our adjudicatory capacity. This increased capacity results in more timely hearings, reduced processing time, increased dispositions, and fewer aged cases. We have been able to reallocate the resources saved due to video teleconferencing toward other initiatives to eliminate the hearing backlog. Our goal is to have a hearing room or video conference site within 75 miles of every claimant. We can realize this goal, though, only if Congress timely enacts the President's budget.

4. **You testified that 118 union ALJs have reduced time because of their union responsibilities and are among those ALJs who do not handle 500 cases. Please identify for the record the names and number of dispositions of these 118 ALJs. What do these ALJs spend their time on? What is the size of the ALJ bargaining unit compared to the size of other bargaining units? Are they required to obtain prior approval for these activities? Are their duties and the time spent on them comparable to the time spent by other union officials? Also, under their collective bargaining agreement, judges can work from home. Why is this? What work gets done from home and how are they held accountable?**

- **Please identify for the record the names and number of dispositions of these 118 ALJs.**

  At the time of the hearing, there were 118 International Federation of Professional & Technical Engineers (IFPTE), Association of Administrative Law Judges (AALJ) union representatives who were eligible to use official time in FY 2011 and 69 ALJs had actually used official time. As of August 29, 2011, because of normal fluctuation in the numbers of union representatives, 130 ALJs were eligible to use official time in FY 2011 and 77 had used official time.

  The enclosed chart lists the 130 ALJs, the amount of official time each ALJ used, and the number of case dispositions he or she issued this fiscal year to date.

- **What do these ALJs spend their time on?**

  Under 5 U.S.C. chapter 71 and our agreement with IFPTE, ALJ union representatives will be granted official time for union representational activities, including:

  1. Term Negotiations—to prepare for and negotiate a collective bargaining agreement.

  2. Mid-Term Negotiations—to prepare for and bargain over issues raised during the life of a term agreement.

  3. Dispute Resolution—to process grievances up to and including arbitrations and to process appeals of bargaining unit employees to the Merit Systems Protection Board (MSPB), Federal Labor Relations Authority, and to the courts.

  4. General Labor-Management Relations— includes meetings between labor and management officials to discuss general conditions of employment, labor-management committee meetings, labor relations training for union representatives, union participation in formal meetings, investigative interviews, and other general labor relations.

The chart below details the breakdown of official time used by ALJ union representatives in FY 2011.

IFPTE	FY 11 Hours
Dispute Resolution	1,203
General Labor Relations	10,572
Mid-Term Negotiations	38
Term Negotiations	4,065
Total	**15,878**

(Through 8/31/11)

- **What is the size of the ALJ bargaining unit compared to the size of other bargaining units?**

The chart below lists the number of IFPTE ALJ bargaining unit employees compared to other Social Security Administration (SSA) bargaining unit employees:

Union	SSA Employees
American Federation of Government Employees (AFGE)	49,625
National Treasury Employees Union (NTEU)	1,518
IFPTE	**1,131**
National Federation of Federal Employees (NFFE)	38

(Through 7/15/11)

- **Are they required to obtain prior approval for these activities?**

Yes. Under the existing agreements, the local AALJ representative submits in advance a Report Form to his or her supervisory Hearing Office Chief Administrative Law Judge (HOCALJ) to request official time as needed. The HOCALJ considers the request based on the purpose and type of official time requested and pending workload needs.

In addition, the AALJ national officers submit to their supervisors an official time projection for the month and a final version at the end of the month indicating total official time used.

- **Are their duties and the time spent on them comparable to the time spent by other union officials?**

  The type of union activities and duties performed by the IFPTE representatives during official time is similar to the type of duties and activities performed by other union representatives. The table below indicates the official time hours per bargaining unit employee for IFPTE compared to agency and government-wide figures.

  OFFICIAL TIME HOURS PER BARGAINING UNIT EMPLOYEE

FY	IFPTE	SSA	GOVT.
2007	17.09	4.64	2.69
2008	17.96	4.63	2.60
2009	14.32	4.10	2.58
2010	15.89	4.18	Not Available

- **Under their collective bargaining agreement, judges can work from home. Why is this? What work gets done from home and how are they held accountable?**

  ALJs, like other employees in flexiplace-eligible positions, can perform many official agency functions from home. The agreement between our Office of Disability Adjudication and Review (ODAR) and IFPTE allows ALJs to perform many of their duties at their alternate duty station (ADS), such as file review, hearing preparation, decision-making, decision instruction preparation, decision drafting, and decision editing. ALJs cannot conduct hearings, face-to-face pre-hearings, or post-hearing conferences at the ADS.

  We expect our ALJs to perform their duties at their ADS with the quality, consistency, and in the same manner as they perform them at the official duty station. To participate in the flexiplace program, an ALJ must provide contact information at the ADS and remain accessible to agency employees during duty hours. In addition, ALJs are responsible for the safekeeping of any case files removed from the hearing office for flexiplace.

  ALJs who elect to work flexiplace must submit a "Flexiplace Log Sheet" to their HOCALJs the next day they are in the office following a flexiplace day. This log sheet lists the cases on which the ALJ worked and the work done. HOCALJs can review these log sheets to ensure that ALJs complete an appropriate amount of work while on flexiplace.

  We have taken steps to address ALJs who fail to perform a full day's work while at their ADS. In May 2009, we reprimanded an ALJ who failed to take home a sufficient amount of work on a flexiplace day. In January 2011, we filed charges

with MSPB to suspend another ALJ who, among other things, failed to take home a sufficient amount of work on four flexiplace days. This case is pending a decision by MSPB.

5. **Is the ALJ hearing open to the public? Why or why not?**

ALJs have always had the authority to determine who may or may not be present at a hearing. Our current regulations provide that the hearing "is open to the parties and to other persons the administrative law judge considers necessary and proper." 20 C.F.R. §§ 404.944, 416.1444.

The vast majority of our hearings involve people who have filed claims for Social Security disability benefits or Supplemental Security Income payments based on disability. By their nature, these hearings require the claimant's representative and the ALJ to ask the claimant about sensitive and private medical issues, such as the nature of the claimant's medical condition and its effect on his or her daily activities and ability to function. The questions asked at a hearing also typically require the claimant to disclose details regarding his or her medical treatment (including mental health treatment in many cases), the extent of his or her use of medication, and other private health-related information. We take seriously our obligation to protect the privacy of the claimants who appear before us. For that reason, the ALJ normally limits attendance at the hearing to the claimant or any other parties to the hearing, the claimant's representative, necessary agency personnel, and any necessary witnesses, such as a vocational expert. No outside observers are present unless the claimant and any other parties consent, and the ALJ finds that the outsider's attendance would not disrupt the hearing.

6. **You testified that 75 to 80 percent of claimants use attorneys or non-attorneys and that their fees are a percentage of the back payment due the claimant. Such payments are made under previously-approved fee agreements. Claimant representatives can also be paid by submitting fee petitions to the Agency after an approval has been made. Please indicate the percentage of representative fees paid under fee petition in FY 2010, and the range of dollar amounts of such fees. Please also identify the officials who have delegated authority to approve those fee petitions and the dollar amount of those delegations.**

In FY 2010, we paid about four percent of title II direct fee payments through the fee petition process. Reliable title XVI data is not readily available. Title II direct fee payments made through the fee petition process ranged as follows:

Range	Count
$10,000 or less	16,227
Between $10,000 and $20,000	635
Between $20,000 and $30,000	118
Between $30,000 and $40,000	21
Between $40,000 and $50,000	4
Between $50,000 and $60,000	1

Delegated authority for authorizing fees under a fee petition depends upon the level at which the claim is decided. For cases resolved below the hearing level, staff in our program service centers review the petition and authorize fees up to $10,000. If the reviewer recommends fees greater than $10,000, we require a second level of review by a specialized unit in ODAR.

For cases resolved at the hearing level, the ALJ or an attorney adjudicator reviews the fee petition and authorizes fees up to $10,000. If the recommended fees are greater than $10,000, the appropriate Regional Chief ALJ will review the recommendation and authorize the fee.

For cases resolved at the Appeals Council, analysts in the Appeals Council's Attorney Fee Branch examine the fee petition and authorize the fee. There is no requirement for a second level of review based on the amount of the authorized fee for Appeals Council fee petitions.

7. **Those appealing their claims may have an attorney or non-attorney representing them. How much did claimants pay their representatives last year? What are the tools you have to ensure representatives are helping claims move through the process as opposed to hindering the process? For example, are they required to file appeals and supporting documents electronically and on a timely basis?**

In FY 2010, we paid more than $1.4 billion in title II direct fee payments to representatives. Reliable title XVI data is not readily available. We do not maintain data for fees that claimants pay directly to representatives, nor do we maintain data for fees that we do not authorize, such as fees paid in certain instances by third party entities such as State governments or insurance companies.

We have developed several electronic appeals applications to make the administrative process more efficient. Claimants and their representatives may file disability appeals

online. Representatives may also submit medical records to us electronically. Many representatives can now electronically access and review their clients' claims folders. Furthermore, we recently published a regulation that will require representatives who request direct fee payment to conduct business with us electronically at the times and in the manner that we prescribe. These rules will become effective on October 12, 2011, and we will publish a notice in the Federal Register when we require those representatives to use our available electronic services.

Our regulations also contain the rules of conduct that representatives must follow, and we can sanction any representative who does not follow these rules. As a part of these rules, representatives may not unreasonably delay the processing of a claim without good cause, or engage in actions or behavior prejudicial to the fair and orderly conduct of our administrative proceedings, including a hearing. If we have evidence that a representative took any of these prohibited actions, we could, after notice and opportunity for a hearing, suspend or prohibit that representative from further practice before the agency.

Finally, when reviewing a representative's fee amount, the reviewing official may take into account the representative's failure to adequately represent his or her client. When reviewing a fee agreement, the official may request administrative review of the fee amount; a different official conducts that review. When reviewing a fee petition, the reviewing official considers the extent and type of services the representative performed. The reviewer could reduce the fee of a representative who harmed his or her client's interest.

8. **Please provide a description of each step of the disability determination appeals process and for each step please clarify whether it is specifically required by statute or regulation.**

In most cases, we decide claims for benefits using an administrative review process that consists of four levels: Initial determination, reconsideration, hearing, and appeal. 20 C.F.R. §§ 404.900, 416.1400. We make an initial determination at the first level. An initial determination is required by sections 205(a) and 1631(c)(1)(A) of the Act, 42 U.S.C. §§ 405(a), 1383(c)(1)(A).

A claimant who is dissatisfied with the initial determination may request reconsideration. In most instances, reconsideration is not required by statute but by our regulations. 20 C.F.R. §§ 404.907-404.913, 404.920, 416.1407-416.1413, 416.1420. The only instance in which the Act mentions reconsideration is for medical cessation cases. In those cases, the Act requires that, if we determine that a beneficiary is no longer disabled, we give the beneficiary the opportunity for an evidentiary hearing before we issue a reconsideration decision. Section 205(b)(2) of the Act, 42 U.S.C. § 405(b)(2).

A claimant who is dissatisfied with the reconsidered determination may request a hearing. The Act requires the Commissioner to give a claimant "who makes a showing in writing that his or her rights may be prejudiced by any decision the Commissioner . . . has

rendered, . . . reasonable notice and opportunity for a hearing with respect to such decision." Sections 205(b)(1), 1631(c)(1)(A) of the Act, 42 U.S.C. §§ 405(b)(1), 1383(c)(1)(A). An ALJ conducts the hearing. 20 C.F.R. §§ 404.929, 416.1429.[1]

We handle requests for ALJ hearings in several ways. Most claimants receive a decision from an ALJ.[2] An ALJ may hold a hearing and issue a fully favorable, partially favorable, or unfavorable decision. An ALJ may also issue a decision without holding an oral hearing if the claimant and any other parties waive their right to appear at a hearing or if the decision is fully favorable. Our regulations also authorize certain attorney advisors in ODAR to issue fully favorable decisions without holding a hearing. 20 C.F.R. §§ 404.942, 416.1442.

If the claimant is dissatisfied with the ALJ's decision, he or she may request Appeals Council review. 20 C.F.R. §§ 404.967-404.968, 416.1467-416.1468. The Act does not require administrative review of an ALJ's decision. If the Appeals Council issues a decision, that decision becomes the final agency decision. If the Appeals Council declines review, the ALJ's decision becomes the final agency decision. A claimant may request judicial review of the final agency decision in Federal district court. Sections 205(g), 1631(c)(3) of the Act, 42 U.S.C. §§ 405(g), 1383(c)(3).

9. **You testified that you would like to see improved communication with and have more input to the Office of Personnel Management (OPM) about ALJ hiring. What specific input would you like with OPM regarding the ALJ exam and register?**

I am pleased to report that on this issue, we are working well with OPM.

For example, our input plays a significant role in OPM's decisions about when to re-administer the examination. Moreover, OPM administered the examination and refreshed the ALJ register on three recent occasions and refreshes the register quarterly when 10-point preference eligible veterans, who are permitted by law to open closed examinations with a register, complete the examination process. In fact, we told GAO and OPM that we are generally pleased with the caliber of the candidates selected under the existing ALJ examination process.

With regard to a new ALJ examination, we have spoken with OPM about the occupational analysis that OPM began to update the ALJ examination instrument. Specifically, in the spring of 2011, agency representatives, including our Chief ALJ, met

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[1] For disability claims, 10 States participate in a "prototype" test under 20 C.F.R. §§ 404.906, 416.1406. In these States, we eliminated the reconsideration step of the administrative review process. Claimants who are dissatisfied with the initial determinations on their disability cases may request a hearing before an ALJ. The 10 States participating in the prototype test are Alabama, Alaska, California (Los Angeles North and West Branches), Colorado, Louisiana, Michigan, Missouri, New Hampshire, New York, and Pennsylvania.

[2] An ALJ may also send the case to the Appeals Council with a recommended decision or dismiss a request for a hearing. 20 CFR § § 404.953(c), 404.957, 416.1453(c), and 416.1457.

with OPM to provide input as to competencies we believe are necessary to be a successful ALJ. Over the summer, we scheduled opportunities for OPM to meet with and observe our ALJs. During these meetings, our ALJs also identified competencies and areas of assessment that would enhance the ALJ instrument. As you know, OPM has the sole responsibility for developing the ALJ examination, and we are confident OPM is committed to building a strong, valid assessment instrument.

At the senior staff level, we have enjoyed open communications with OPM's Director Berry and others, including OPM's General Counsel, Elaine Kaplan. I recently met with Director Berry and Ms. Kaplan, and our staffs recently conferred on a number of matters that we raised over the past year, including prompt attention to our objections to ALJ candidates. Although we raised formal objections only to a small number of candidates received on certificates, we were concerned that the decisions on some of those cases took some time to be resolved. I am confident OPM appreciates the impact that objections have on the agency's hiring process. If we have such concerns in the future, we will submit the needed documentation promptly and upon receipt, and OPM will move expeditiously to investigate and decide these matters.

10. How much does it cost the taxpayer, on average, to fire a judge, including their salary?

We estimate that the administrative costs to fire an ALJ can be over $1 million. These costs include paying two years of salary to the ALJ while waiting for a final MSPB decision and the time and salaries of all SSA personnel involved in the investigation and resulting hearing. They do not include costs to the MSPB or the Federal courts.

11. You testified that Congress should consider changing current law to suspend an ALJ's salary after the first level of determination. Could you please clarify your thoughts on this issue and specify what you are referring to by the "first level of determination"?

Most Federal employees receive notice of proposed disciplinary action from their first-line supervisor, followed by a short period (10 to 30 days) during which the employee is afforded an opportunity to orally, or in writing, provide a reply to the proposed discipline. After that, the deciding official considers all relevant information and makes a decision. As soon as the deciding official issues the decision letter, the employee is subject to the discipline and associated salary consequences.

The employee may then challenge the disciplinary action by filing a grievance or appealing to MSPB or the Equal Employment Opportunity Commission, as appropriate, and if successful, seek back pay to recoup any salary due.

By contrast, our ability to discipline an ALJ is constrained by 5 U.S.C. 7521. Pursuant to that statute, we must request approval from MSPB before we suspend or remove an ALJ for misconduct. Furthermore, while we wait for that approval, we must continue to provide the ALJ full salary and benefits.

The process for obtaining MSPB approval can be time consuming and very expensive. An MSPB-assigned ALJ issues an initial decision only after the parties have engaged in discovery and presented evidence and arguments at a hearing. Following the initial decision, either party may file a petition to request the full MSPB to review the initial decision; the full MSPB often takes several months to consider the matter before issuing a final decision.

The entire MSPB process takes two to three years. During this time, the accused ALJ continues to receive full salary and benefits. Thus, the current process forces us to choose between allowing an ALJ who has engaged in misconduct to continue to issue decisions and placing the ALJ on administrative leave with full pay.

I suggested suspending an ALJ's salary after the initial MSPB decision to minimize payments to ALJs who have engaged in misconduct, while providing a means to allow for back pay in those rare instances that the final decision of MSPB differs from the initial decision. We would still need MSPB approval to suspend or remove an ALJ for misconduct.

12. Currently, an ALJ is hired directly into a career status. What do you think about a tracked approach to the ALJ process, with set benchmarks that must be met before an ALJ is on the career track, like a professor earning tenure?

We assume "tracked approach" refers to appointing new ALJs for an initial term, with the understanding that they would become permanent if reappointed. Let me emphasize that the benchmarks established under this approach would need to be clear and uphold a claimant's right to a fair hearing and decision. Such an approach would require a legislative change.

13. The recent Wall Street Journal article about the judge in West Virginia raises a number of questions. From all accounts, this ALJ has had high approvals and high production numbers for some years, so how did he escape management's notice for so long? Why did it take a *Wall Street Journal* article for the agency to begin to investigate?

Congress has long expressed interest in the quality of our hearings. The Bellmon Amendment, enacted as part of the Social Security Amendments of 1980, required us to establish a program to review ALJ decisions on our own motion. As a result, we instituted the "Bellmon Review Program" (Bellmon), which initially targeted ALJs with high allowance rates. Amid significant controversy and litigation about Bellmon's effect on an ALJ's qualified decisional independence, we modified the selection criteria used to conduct own motion review and stopped targeting ALJs with high allowance rates. The litigation surrounding Bellmon had a long-lasting chilling effect on ODAR management's perception of their ability to manage ALJs' work products.

After Bellmon, our Office of Quality Performance (OQP) began conducting nationwide post-effectuation reviews of a limited number of unfavorable, partially favorable, and fully favorable decisions. For these reviews, we used a sample that was large enough to establish a baseline for quality. However, the sample was not large enough to identify possible improvements in the application of the disability adjudication process. Additionally, the Appeals Council, in conjunction with OQP, conducted a limited number of pre-effectuation reviews of favorable decisions.

In recent years, we began reviewing larger numbers of favorable decisions to spot potential policy and allowance trends. We now have new case processing tools that provide structured data on the way in which ALJs and other adjudicators apply agency policies at all steps of the disability process. We analyze this structured data to identify training needs and potential policy and procedural improvements.

In September 2010, we established the Division of Quality (DQ) in ODAR's Office of Appellate Operations. DQ conducts pre-effectuation reviews of unappealed fully favorable and partially favorable decisions to ensure policy compliance, factual accuracy and procedural adequacy in the hearings and appeals process. During its first year of operation, DQ will review 3,500 favorable decisions. We will be better able to identify trends such as those outlined in the Wall Street Journal article and quickly implement remedial measures.

Beginning this year, DQ is also identifying procedural actions or decisions made by ALJs whose decisions fall substantially outside of the statistical norm: unusually high or low allowance rates, dismissal rates, remand rates, on-the-record decision rates, or exceptionally short hearings. DQ has sampled these cases to determine the reasons for the statistical abnormality. To date, DQ has shared its findings with various agency components and has been integral in helping the agency take steps to improve its disability adjudication process and quality assurance procedures.

14. In 2010 there were 54 judges awarding benefits in over 85 percent of their cases. What can you do to manage extreme differences between approvals and denials? What if you suspect a judge's award rate means rubberstamping approvals? What do you do and how can you be sure that these outliers aren't awarding benefits to people who aren't really disabled? What effect do outliers have on the rest of the corps and the public's perception about the fundamental fairness of the system?

As I explained in my testimony, we cannot discipline an ALJ based exclusively on his or her allowance rate because Congress has determined that ALJs should have qualified decisional independence. However, during my tenure as Commissioner, we have taken action against ALJs based on performance and conduct issues.[3] The Administrative Procedures Act (APA) provides the agency with the authority to ensure fair and policy

[3] OPM has noted that, pursuant to 5 U.S.C. § 7521, such actions are permissible only when they rise to the level of "good cause," as that term is interpreted by the MSPB and its reviewing courts.

compliant decisions. Pursuant to that authority, we are taking steps to ensure ALJs issue accurate, policy-compliant decisions. We have implemented pre-effectuation quality reviews of ALJ decisions. We have established expectations for the number of decisions each ALJ should issue each year. As an additional quality measure, we are limiting the number of cases an ALJ may decide annually. We are also conducting post-effectuation reviews of ALJ decisions to ensure that judges follow agency policy and to provide training and counseling to ALJs who misapply our policies and procedures.

15. **You mention a recent initiative to look at a statistical sampling of ALJ awards to identify patterns of disconnect with the law. Please give the specifics of this initiative and identify who is in charge of the sampling and the analysis?**

As discussed above, consistent with the regulatory authority in 20 CFR 404.969 and 20 CFR 416.1469, DQ has been looking at a statistically valid sample of unappealed fully favorable and partially favorable decisions this fiscal year. ALJs issued the majority of the decisions reviewed, but DQ also reviews decisions issued by attorney advisors in the hearing offices. DQ will review 3,500 cases this fiscal year, which we randomly select when the ALJ or attorney advisor issues the decision. We sample an equal number of cases from each region and the NHCs.

DQ analysts review the cases and make recommendations as to whether the decision is supported by substantial evidence. If substantial evidence supports the decision, we forward the decision for effectuation. If the decision is not supported by substantial evidence or if it contains an error of law or abuse of discretion, the Appeals Council can remand the case to the hearing office for further development and a new decision, or issue its own decision. That decision may be corrective, unfavorable, less favorable, or more favorable. We notify the claimant and their representative, advising them that the Appeals Council exercised own motion review and provide information on the Council's proposed action.

Robert Johnson is the Chief Administrative Appeals Judge in DQ, and Carmine Borrelli is the Acting Division Director.

16. **A case changes with each appeal since the record remains open, meaning new medical evidence or other information may continue to be added. The open record concept is different from other Administrative Procedures Act (APA) proceedings. Would you talk about the pros and cons of an open record and how you have studied these issues since you've become Commissioner? What happens if new evidence comes in after the ALJ has made a decision? Does the claimant get a new hearing? What are the costs, in particular at the hearing and Appeals Council levels, of keeping the record open?**

Under section 202(j)(2) of the Act, an application for benefits filed before the first month in which a claimant satisfies the requirements for benefits remains a valid application through the date of the ALJ's decision. In accordance with the Act, our regulations allow a claimant to submit evidence at and after a hearing. Our policy requires the ALJ to ask

the claimant or representative if they have any additional evidence to submit before closing the hearing. If there is no additional evidence, the ALJ makes a decision based on the existing record. If the claimant or representative has additional evidence to submit, the ALJ will keep the record open to allow for its submission. The ALJ decides how much time to allow, and, once that time has passed, the ALJ issues a decision. If new evidence is submitted to the ALJ after the decision is made, the ALJ can reopen and revise the decision if the regulatory requirements in 20 CFR 404.987 – 989 or 20 CFR 416.1487 - 1489 are met.

Under our regulations, claimants requesting Appeals Council review of an ALJ decision have an opportunity to submit additional evidence. However, this additional evidence must be both *new* and *material* to warrant Appeals Council consideration. To qualify, the evidence must not be duplicative, cumulative, or repetitive; must affect the ALJ's findings or conclusions; and must relate to the period on or before the date of the ALJ's decision. The primary reason the Appeals Council remands an ALJ hearing decision is that it received new and material evidence. When the Appeals Council remands a case to an ALJ, the prior decision is vacated and the Appeals Council directs the ALJ to issue a new decision after offering the claimant an opportunity for a new hearing.

Because most requests for Appeals Council review are accompanied by additional evidence and representatives often submit voluminous amounts of evidence that are duplicative, cumulative, or repetitive, there are administrative costs associated with reviewing evidence to determine whether it meets the *new and material* standard. The administrative costs of keeping the record open are not readily available.

Claims in Region I, which includes Massachusetts, Connecticut, New Hampshire, Maine, Rhode Island, and Vermont, are subject to special hearing procedures and evidence rules. In Region I, a claimant has 75-days notice of a hearing, as opposed to 20 days in the rest of the country, but must submit evidence no later than 5 days prior to the hearing, unless certain exceptions apply. Once the ALJ issues a decision, the record is closed. Claimants can submit new evidence to the Appeals Council only if it relates to the period on or before the date of the ALJ hearing decision, there is a reasonable probability that the evidence would change the outcome of the decision, and the claimant shows good cause for not submitting the evidence earlier.

17. **What does it cost to process an initial decision by a State Disability Determination Service that is 100 percent federally funded? What does it cost to process a request for a hearing? What accounts for the difference and what actions have been taken to bring down hearing costs while still fully protecting the due process rights of claimants?**

In FY 2010, an initial disability decision by a State disability determination services (DDS) cost $1,131 and a hearing cost an additional $2,817. Most of the higher cost of hearings is attributable to higher personnel costs, including the costs of ALJs. Furthermore, at the hearing level, cases are older and have more medical information than at the initial stage, so the review is lengthier and more complex.

We continually seek to improve the efficiency of all our workloads, including hearings. In 2007, we set productivity expectations for our ALJs. We also extended the expiration date of the regulatory authority that allows senior attorneys to issue fully favorable decisions in cases that do not require a hearing. This procedure frees up time for the ALJs to hold hearings and decide cases that are more complex. Video technology has allowed us to conduct more cost-effective hearings by reducing ALJ travel. It has also allowed us to schedule and handle more hearings, allows an available ALJ to hold a hearing regardless of his or her location, and provides better service to claimants in remote areas that are not located near a hearing office. We are discontinuing visits to all but 10 hearing office temporary remote sites, which was an inefficient, costly, and potentially unsafe way for us to do business.

18. According to the Wall Street Journal article, Judge Daugherty was assigning himself all of the cases from one particular lawyer. Isn't this a breach of policy, and how was this allowed to happen?

According to long-standing agency policy, the HOCALJ assigns cases to ALJs. The HOCALJ can delegate this responsibility to a management designee, generally the hearing office director. Hearing offices maintain a "master docket" that lists all requests for hearings and remands received. The HOCALJ generally assigns cases to ALJs from the master docket on a rotational basis, with the earlier requests for hearings receiving priority, unless there is a special situation that requires a change in the order in which a case is assigned. Once a case has been assigned to an ALJ, the situations in which a HOCALJ will reassign a case to another ALJ are quite limited.

To ensure compliance with these requirements, the Office of the Chief Administrative Law Judge issued a reminder to all HOCALJs, hearing office directors, and regional office management teams in June 2011 on the agency's policies, rules, and regulations on case assignment. In June 2011, we also modified our hearing level Case Processing Management System (CPMS), which prevent line ALJs from assigning themselves cases. With this additional safeguard in place, only management-authorized employees within the hearing office have the ability to assign cases in CPMS. It is a violation of agency policy for ALJs to use the master docket to reassign cases, whether to themselves or another ALJ.

With respect to Judge Daugherty, our independent Inspector General's investigation remains open, so we are not able to comment on the particulars of the investigation.

19. In your written testimony you cite peer review as one way to enhance ALJ performance management. How would you implement a peer review program at SSA?

We have taken steps to implement a modified ALJ peer review program. Since we established the DQ, Appeals Officers and Administrative Appeals Judges (AAJs) in the Appeals Council have been responsible for determining if own motion review is

warranted in the randomly sampled fully favorable and partially favorable hearing and attorney advisor decisions. Early next fiscal year, ALJs will also be involved in the DQ review process and will work alongside AAJs in reviewing the randomly sampled decisions.

20. If SSA had been unable to draw down reserves in its information technology carryover fund in order to compensate for funding shortfalls in FY 2011, would the agency have had to resort to staff furloughs?

We need most of our information technology (IT) funding each year just to maintain our daily operations. We use it to pay for the systems that answer our phones and store medical information for disability claims. Without it, we would need significantly more funding to complete the same amount of work.

In FY 2011, we will use over $400 million in carryover funding for IT expenses. Without this carryover funding, we would have needed to divert more of our limitation on administrative expenses funding toward essential IT spending in FY 2011, which would have reduced the funds available for other critical expenses, including salaries. We also would have had to freeze hiring in our hearing offices, jeopardizing our goal of eliminating the hearings backlog by the end of FY 2013 and leading to longer waiting times for the public.

If we had been unable to draw down reserves, furlough days would have been likely since we already have made hard cuts, including the following: freezing hiring agency-wide with the exception of limited personnel for our hearing offices; significantly reducing overtime; stopping service at most field office and hearing office remote service sites; closing field offices 30 minutes early; not opening a planned teleservice center or eight new hearing offices; and suspending Social Security Statements.

Each $25 million reduction to our budget represents one furlough day for agency and DDS employees. For each furlough day, we would not be able to complete approximately 19,000 retirement claims, 11,000 initial disability claims, and 3,000 hearings.

21. Please provide the number of ALJs who, in FY 2010, approved cases at a rate that was 25 percentage points higher than the national average approval rate, and how many ALJs approved cases at a rate that was 25 percentage points lower than the national average approval rate (considering approvals as a fraction of all dispositions).

In FY 2010, the national approval rate was 61 percent. There were 44 ALJs whose approval rate was 86 percent or higher and 117 ALJs whose approval rate was 36 percent or lower.

22. You testified that because disability decisions are made under the Social Security Act and not the APA, there is some question about whether the Agency could review ALJ decision-making. We take this to mean that while the decision-maker in APA proceedings was intended to be independent, the decision-maker in SSA proceedings, who is making decisions for the Commissioner, may have some level of accountability to the Agency under the Social Security Act. Is that true? What analysis have you made about what the Social Security Act would require? How do

those requirements exist with respect to the APA? Based on the Social Security Act's requirements, will you develop management parameters for your ALJs?

The level of accountability an SSA ALJ has to SSA is the same level of accountability that an ALJ who works for another agency has to that agency. There is no difference between our ALJs and other ALJs in that regard. Our ALJs are hired in the same manner as other ALJs, and they have the same qualified decisional independence that other ALJs have. Because of their qualified decisional independence, we ensure that ALJs make their decisions free from agency pressure or pressure by a party to decide a particular case, or a particular percentage of cases, in a particular way. However, an ALJ's qualified decisional independence does not prevent appropriate management oversight of our administrative review process or prevent us from establishing administrative practices and programmatic policies that ALJs must follow. We have made it clear to our ALJs that they must be impartial in conducting hearings and they must decide each case in accordance with agency policy set out in our regulations, rulings, and other policy statements. The management parameters that we follow are consistent with this understanding of the law.

The Supreme Court addressed the relationship between the APA and the Social Security Act in Richardson v. Perales, 402 U.S. 389, 408-409 (1970). In Perales, the Supreme Court considered whether the APA, rather than the Social Security Act, "governs the processing of claims." The Supreme Court stated that, "We need not decide whether the APA has general application to social security disability claims, for the social security administrative procedure does not vary from that proscribed by the APA. Indeed, the latter is modeled upon the Social Security Act." In light of the Supreme Court's holding in Perales that the administrative procedures required by the Act do not vary from those required by the APA, we have consistently held the view that the APA and the Act complement one another, and that the hearing procedures required by the APA and the Act are consistent. However, in the event of any inconsistency between the two statutes, the specific provisions of the Social Security Act would apply.

Enclosure

SOCIAL SECURITY

The Commissioner

December 13, 2011

The Honorable Sam Johnson
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your November 2, 2011 letter requesting additional information to complete the record for the hearing on work incentives in our disability programs. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

I am sending a similar letter to Chairman Davis.

Sincerely,

Michael J. Astrue

Enclosure

cc:
Kim Hildred, Staff Director
Subcommittee on Social Security
House Committee on Ways and Means

Questions for the Record
For the September 23, 2011 Hearing
On Work Incentives in SSA's Disability Programs

1. **The Ticket Act, signed into law in 1999, required demonstration projects to test alternative ways to reduce benefits based on earnings. Specifically Congress has been waiting for an answer on the effects of replacing the so-called "cash cliff" where workers lose all benefits if they earn just $1 above the substantial gainful activity cap ($1,000 this year), with a gradual benefit offset, the so-called Benefit Offset National Demonstration (BOND). It's now almost 15 years later and we still don't have a final report. As a matter of fact, in the agency's testimony we are told the final report won't be out until 2017, which is 18 years after the Ticket Act became law. What can you tell us about your results thus far? What specifically will you learn by 2017 that you don't know now?**

   We began to implement the BOND demonstration project in 2005; that year, we awarded contracts to four States (Connecticut, Utah, Wisconsin, and Vermont) to test a $1 benefit offset for every $2 earned above substantial gainful activity (SGA) in combination with benefits counseling. We implemented this small pilot first to help inform our national demonstration project. The small pilot used a manual process instead of building an automated system for delivering notices and adjusting benefit payments. We used our experience from the pilot to identify the extensive systems work that was necessary to create an automated process of delivering notices and benefit payments for the much larger sample of beneficiaries in the BOND. We also awarded a contract to Abt Associates to design a national benefit offset demonstration. Abt completed the national design in 2008, and final reports from each of the four States involved in the pilot are available on our website at: http://www.ssa.gov/disabilityresearch/offsetpilot.htm.

   The four-State pilot found:

   - No statistically significant effect of the offset on the percentage of participants with earnings;
   - A statistically significant effect of the offset on the percentage of participants with earnings above SGA, in the two years after we randomly assigned participants, of between 3.72 and 4.55 percentage points;
   - No statistically significant effect of the offset on the average earnings of those participants with earnings; and
   - Statistically higher benefits (over $500) paid to participants receiving the benefit offset.

   The limitations of these findings are that they applied only to beneficiaries who volunteered to participate in the project within each State and are not applicable to the broader population.

Before we began implementing BOND nationally in 2009, we adjusted the Abt national design based on the results of the four-State pilot. We started enrolling participants in BOND in 2010 and began data collection in 2011. We require at least five years of data to ensure that the results have long-term, national applicability, which is why BOND does not end until 2017.

Because BOND is a national demonstration project that includes non-volunteers, its outcomes will be nationally applicable. It will show:

- The effect of a $1-for-$2 benefit offset in combination with enhanced work incentives counseling on wages, Social Security benefits, job retention, and hours worked;
- The costs and benefits of offsetting benefits to the Social Security trust funds, the Federal government, and State and local governments; and
- The beneficiary subgroups for whom the interventions are effective.

You can find more information on BOND on our website at: http://www.ssa.gov/disabilityresearch/offsetnational.htm.

Since we are still enrolling participants, we do not have meaningful preliminary data.

2. How much has the taxpayer paid so far for this work? How much will they have paid by the time your work is done?

We spent $9.4 million on the four-State pilot. In addition, we spent $10.6 million on the BOND design contract and $22.9 million on the BOND implementation and evaluation contract. Our total costs to date on the benefit-offset effort are approximately $42.8 million. Our total contracting costs for BOND implementation and evaluation are estimated to be about $128 million through 2017, and we do not anticipate adding additional funds to the contract. Accordingly, we estimate that total costs of the BOND effort will be approximately $148 million, which is 22 percent less than the $190 million estimated by the Congressional Budget Office in 1999.

The costs of the BOND only include administrative costs. BOND may lead to either increases or decreases in benefit payments depending on its effect on beneficiary work behavior. We designed BOND to determine the net impact of benefit offsets on benefit payments and Medicare costs.

3. The President's budget request seeks to reauthorize and expand section 234 demonstration authority to conduct various new demonstration projects, including the Work Incentives Simplification Proposal (WISP) to test the treatment of beneficiary earnings. If the WISP demonstration project were authorized, would the taxpayer still need to fund the BOND demonstration project, and if so, why? What gaps would the WISP project fill that the BOND project is not slated to meet? What will you do with the information you garner from BOND while you are awaiting the outcomes from WISP? Further, it appears that WISP would eliminate

work as a reason for terminating benefits, so does this mean that those who earn enough will gradually come off cash benefits but continue to be entitled to Medicare? If so, for how long?

Should Congress authorize a WISP demonstration, current law requires that we continue BOND. Consistent with Congress' intent, we designed BOND to test the advantages and disadvantages of replacing the complete loss of benefits (i.e., the cash cliff) that occurs when a beneficiary performs SGA with a more gradual $1 reduction in benefits for every $2 in earnings above the SGA earnings amount. BOND does not address other work incentive policies or post-entitlement procedures.

WISP addresses a significant disincentive to work that occurs under the current rules: the fear of losing benefits due to work activity. The current set of Social Security Disability Insurance (SSDI) work incentive policies and post-entitlement procedures have become very difficult for the public to understand and for us to effectively administer. The goal of WISP is to simplify SSDI work rules to encourage beneficiaries to work and reduce our administrative costs. WISP would eliminate complex rules on the Trial Work Period (TWP) and the Extended Period of Eligibility. It would also eliminate performing SGA as a reason to terminate Disability Insurance (DI) benefits. Further, we would count earnings when they are paid, rather than when earned. WISP would allow us to replace the complex work continuing disability review (CDR) process with a streamlined work review process. In addition, if a beneficiary's earnings fell below a certain threshold, we could reinstate monthly benefit payments as long as the person was still considered to be disabled. We are still considering the design of the demonstration in light of health care reform changes and coverage expansion that will occur over the next few years.

Currently work rules are different in the Supplemental Security Income (SSI) program. Two different sets of work rules make returning to work even more confusing for individuals receiving benefits from both programs. Our WISP proposal will better align the SSDI program with the SSI program. These changes would also create a better foundation for the potential inclusion of a benefit offset like what we are testing with the BOND project.

4. **What is the expected cost of the WISP project, and would you break out those costs by benefit costs, Medicare costs, and administrative costs? What is the agency's projected timing for completing the WISP project, if authorized, and when would WISP results be available?**

We are convening a Technical Advisory Panel, as recommended by the Government Accountability Office (GAO), to provide us with independent and informed recommendations for the design and evaluation of a WISP demonstration. Until we have the panel's recommendations for a demonstration design, we cannot provide precise WISP cost estimates. Moreover, we need legislation to initiate WISP, and the authorizing legislation could affect project design. We will provide cost estimates as soon as we have the information available to do so. The project design phase will also help us develop an informed project time line for completing WISP.

Our rough timeline for the project proposes two years to develop the infrastructure necessary to implement WISP and at least five years after implementation of WISP to obtain good information on the potential costs and benefits. Our rough estimate is that WISP will cost less than BOND. Our rough estimate only includes the administrative costs. WISP may lead to either increases or decreases in benefit payments depending on its effect on beneficiary work behavior. We will design WISP to determine the net impact of benefit offsets on benefit payments and Medicare costs.

5. **In Mr. Williams' testimony and the SSA's FY 2012 budget request, there is a program called PROMISE, Promoting Readiness of Minors in Supplemental Security Income (SSI). We are aware it is a joint effort with the Departments of Labor and Education, and includes incentive payments to states that can successfully serve the SSI youth population. Can you please tell us more about this project, including the funding, and how it is different from the current Youth Transition Demonstration?**

PROMISE is an interagency pilot project with the Departments of Education, Labor, and Health and Human Services to improve outcomes for youth receiving SSI payments through better, more-strategic provision of services to children with disabilities and their families. The pilot demonstrations would focus on a range of situational concerns, such as health status, physical and emotional development, completion of education and training, and employment. PROMISE would use competitive grants to test and evaluate interventions and include incentives to States to improve the educational and economic well-being of children receiving SSI and their families. In conjunction with improving outcomes, PROMISE aims to reduce reliance on SSI and, in the long run, other public services through greater self-sufficiency.

PROMISE will address common barriers to positive outcomes for child recipients by encouraging innovation through better coordination between existing programs and services, particularly around the transition to competitive, integrated employment, completion of postsecondary education, and other activities that are likely to reduce the probability of future dependency on SSI. The program also intends to help families of child SSI recipients through improved services and supports such as education and training.

The Administration proposes $40 million in total funding for PROMISE. The Department of Education requests $30 million in funding to award competitive grants to States to implement PROMISE pilot projects. We request $10 million in funding to rigorously evaluate the impact of these projects and provide outcome-based payments to incentivize effective and efficient services.

Both PROMISE and our current Youth Transition Demonstration (YTD) share a similar aim of improving outcomes for youth who receive SSI payments. YTD provides transition services that are intended to lift the barriers facing youth with disabilities and encourages work by allowing youth to retain more of their benefits with increased

earnings. Lessons learned from YTD will help inform the PROMISE demonstration. PROMISE will be distinct from YTD in a number of ways. PROMISE will:

- feature collaboration across four Federal agencies, each with programs and services that touch children with disabilities and their families, to help states adapt diverse resources to a common purpose;
- target the entire family, in order to address a wider array of barriers to greater self-sufficiency than can be addressed by services that only target the child; and
- utilize incentive payments to reward success in improving key outcomes for this vulnerable population.

6. Please provide the following information for the Protection and Advocacy for Beneficiaries of Social Security (PABSS) programs for FY 2011:

a. Number of beneficiaries who received PABSS services broken out by whether they are Disability Insurance (DI), SSI, or concurrent beneficiaries.

In fiscal year (FY) 2011, our technical assistance provider, the National Disability Rights Network (NDRN), reported that 2,433 new service request cases were opened in FY 2011 with the following breakout by type of benefit:

SSI	**660**
SSDI	1506
Concurrent	**267**
Total NEW Beneficiaries Cases Opened	2433

In addition, NDRN reported that 4,858 beneficiaries received information and referral (I&R) services.

b. The specific services provided.

The PABSS grantees provided I&R and in-depth services to beneficiaries. I&R are short-term interventions that range from simply referring a beneficiary to a more appropriate service provider to making calls or writing letters on a beneficiary's behalf. A service request involves more in-depth assistance than I&R; these services range from short-term problem solving to litigation help.

c. Performance outcomes used to determine the effectiveness of the PABSS program and the assessment of the PABSS program effectiveness using those outcomes.

The primary goal of the PABSS grantees is to advocate for the removal of barriers to work. While certain barriers (such as the need for reasonable accommodation) occur frequently, each beneficiary may experience different barriers. Therefore, the Protection and Advocacy (P&A) programs can focus on addressing certain

barriers and choosing cases based on the merits of the beneficiary's need for assistance. To maintain the flexibility of the PABSS, we do not dictate the number or types of cases a grantee must take. Instead, we outline the general nature of the services as part of the terms and conditions of the award.

We monitor the services PABSS grantees provide by reviewing the Program Performance Reports. These reports offer numerical and narrative information about the project activities supported under PABSS funding. Our project officers review those reports to ensure that the cases described fit within the grant's mission. NDRN also reviews the reports to identify technical assistance needs of individual projects and technical trends across the P&A network.

According to NDRN, PABSS grantees achieved the following outcomes in FY 2011:

a. Individual gained / maintained access to services including those of VR, EN or other agency	404
b. Individual obtained employment	27
c. Individual regained employment	11
d. Individual maintained employment	92
e. Individual advanced in employment	5
f. Individual's employment opportunities increased	151
g. Individual obtained an increase in salary and/or benefits	23
h. Validity of discrimination complaint was upheld	18
i. Overpayment situation addressed (it does not matter if it was waived or the efforts were not successful)	299
j. Individual acquired knowledge concerning his/her rights	1,191
k. Outcome information is not available	76
l. Other outcome	66
Total outcomes of closed issue area service requests	2,363

d. Also, if PABSS's authorization were to expire, could the SSA continue to fund PABSS services under other existing statutory authority? Please specify the authorities you would use.

In recent years, Congress has reauthorized PABSS in section 1150 of the Social Security Act and provided funds for PABSS in our annual appropriation. If Congress elected to continue the PABSS program, but allowed the specific authorization in section 1150 to expire, it is possible, subject to available resources, that we could continue to fund the PABSS program under section 201(g)(1) of the Social Security Act, which authorizes us to pay the costs of administering Title II and XVI programs using our annual appropriation.

Although with our limited discretionary authorities, we might have to reduce other mission-critical priorities, such as initial claims, disability hearings, and program integrity work.

7. Please provide the following information for the Work Incentives Planning and Assistance (WIPA) program for FY 2011:

a. Number of cooperative agreements nationwide.

We have 102 WIPA cooperative agreements nationwide.

b. Number of Community Work Incentive Coordinators, number that are part time, number that are subsidized by other funding sources.

As of November 7, 2011, we had 689 certified Community Work Incentive Coordinators (CWICs). Based on personnel forms from each WIPA, we estimate that approximately 40 percent of the total certified CWICs work part-time (defined as less than 35 hours per week).

To receive funding from us, WIPA projects must provide a five percent match from non-Federal sources. Some WIPA projects also leverage funds or support from other organizations. Other funding is obtained in a variety of ways, such as parent organization funding and Medicaid Infrastructure Grant funding.

In September 2011, Mathematica Policy Research (Mathematica) published its third WIPA evaluation report; the report covered a one-year period from April 1, 2010 to March 31, 2011. This report includes the following table, which provides a breakdown of the number of WIPA projects that met the required match and leveraged additional funds from other sources:

Other Funding Leveraged by WIPA Projects as a Percentage of SSA Funding

Non-SSA Funding for Direct Services as a Percentage of SSA Funding	Number of WIPA Projects
5-9	24
10-24	13
25-49	9
50-74	1
75+	11

c. Number of beneficiaries who received WIPA services broken out by whether they are DI, SSI, or concurrent beneficiaries.

According to the Mathematica report cited in our response to Question 7b, from April 1, 2010 to March 31, 2011, 24,706 beneficiaries enrolled to receive WIPA services. Below is the breakout by benefit type.

SSDI only	15,404
SSI only	5,738
Concurrent SSDI and SSI	3,564
Total beneficiaries served	24,706

d. The specific services provided.

Our WIPA grantees offer I&R and intensive services to our disability beneficiaries. I&R consists of providing general information about work incentives and referrals to support services; these services help a beneficiary determine his or her work goals and the best way to achieve them.

Intensive services include:

- Counseling individuals on available options for obtaining or maintaining employment based on their goals and abilities;
- Providing individualized information to beneficiaries regarding the effect of changes in employment or personal circumstances on their benefits and health care coverage; and
- Providing long-term assistance and support to beneficiaries as changes occur in their employment and benefits status.

e. Performance outcomes used to determine the effectiveness of WIPA programs and assessment of the WIPA program using those outcomes.

For the WIPA projects, we have developed nine benchmarks (enclosed) and one annual performance indicator. The annual performance indicator will measure the extent to which the WIPA services facilitated beneficiaries achieving self-sufficiency. We first included the benchmarks and annual performance indicator in the Terms and Conditions of the WIPA grants for the sixth year of the program beginning on July 1, 2011.

Since these are new performance measures, we do not yet have enough data to assess the effectiveness of the WIPA program. We are developing a companion Services Report that will allow us to monitor the projects' performance and progress toward meeting the nine performance benchmarks. Moreover, we will annually compare WIPA data with our data to assess the projects' and overall program's success in meeting the annual performance standard.

f. Also, if WIPA's authorization were to expire, could the SSA continue to fund WIPA services under other existing statutory authority? Please specify the authorities you would use.

In recent years, Congress has reauthorized WIPA in section 1149 of the Social Security Act and provided funds for WIPA in our annual appropriation. If Congress elected to continue the WIPA program, but allowed the specific authorization in section 1149 to expire, it is possible that, subject to available resources, we could continue to fund the WIPA program under section 201(g)(1) of the Social Security Act, which authorizes us to pay the costs of administering Title II and XVI programs using our annual appropriation. Although with our limited discretionary authorities, we might have to reduce other mission-critical priorities, such as initial claims, disability hearings, and program integrity work.

8. What quality assurance oversight is now being used for Employment Networks (ENs)? What performance measurement criteria are being used to assess whether ENs are meeting beneficiary and taxpayer needs?

As a part of our ongoing efforts to improve the Ticket to Work program (Ticket program), we established a quality assurance unit to monitor ENs. This unit developed and implemented new processes and procedures to verify the qualifications of prospective ENs and monitor the performance of current ones.

In April 2011, we released an EN solicitation announcement that included new criteria for assessing EN qualifications and defined EN performance standards more clearly. These standards (enclosed) are a part of every EN agreement and measure whether the ENs substantially provide the services they agreed to provide to the beneficiaries they serve. They also measure job placement rates for each EN and the extent to which the ENs helped our disability beneficiaries achieve SGA-level earnings. These standards also require that ENs maintain at least quarterly contact with beneficiaries to assist with job retention. Moreover, we expect ENs to assist beneficiaries in achieving financial independence when possible.

9. In their recent report, the U.S. Government Accountability Office (GAO) found that the SSA has not consistently monitored or enforced the timely progress of ticket holders who assign their tickets to ENs and VRs in order to assess whether they should continue to be exempt from medical continuing disability reviews. Are these reviews being done promptly and accurately? Who conducts these reviews? What process is used to complete these reviews? Is this process based on self-reports and if so is this information independently verified? How timely are these reviews? Is there a backlog? If so, what is the size of this backlog and when will it be eliminated?

The GAO study is now out of date. We are now conducting regular Timely Progress Reviews (TPR) to ensure that individuals who participate in the Ticket program make enough progress each year to continue to have their medical CDRs suspended. In

November 2010, we lifted the moratorium on TPRs, and we have kept current with this workload since May 2011. Each Ticket participant whose benefits have not been suspended because of work and earnings receives a TPR once a year on the anniversary of signing their Individualized Work Plan.

Completing the TPR requires us to check our records for work and earnings information that indicates a disability beneficiary is making the expected progress. If we have earnings information that satisfies our timely progress requirement, the review is complete. If we do not have this information, we mail a questionnaire to the beneficiary, and in some cases the beneficiary's employment support service provider, asking whether the beneficiary has achieved the expected level of progress with work and earnings or education over the past 12 months.

We are in the process of implementing quality assurance procedures to validate the earnings beneficiaries certified they had accumulated. We are also planning to contact a random sample of beneficiaries who certified that they met the educational criteria to request proof of their achievement.

10. Has the SSA established clear performance standards with outcomes measured in terms of the extent to which program funds are devoted to promoting the employment and financial independence of beneficiaries for Ticket to Work? If it has, what are these standards and outcome measures? If it hasn't, why not?

We hold ENs to specific standards, as detailed in both our regulations and the agreements ENs sign in order to be a part of the program. The Ticket program's payment structure (outcome payment system and outcome-milestone payment system) provide clear performance standards for payment. All EN payments are tied to achieving certain employment-related milestones and outcomes.

11. What is the return on taxpayer investment in the Ticket to Work program? What were the costs of the Ticket to Work in FY 2011? What were the benefit savings due to Ticket to Work in FY 2011? Is Ticket to Work self-financing today? Will it be in the future, and if so, when?

Overall, we estimate that we spent approximately $46 million to run the Ticket program in FY 2009, including the cost of agency staff responsible for overseeing the program, milestone and outcome payments to ENs, and support contracts; this estimate is the best and most current one available for program costs. There are several reasons we cannot provide a definitive answer to the return on investment question. For example, we cannot estimate the exact amount of the cost savings, as we explain below.

Regarding benefit savings, we estimate that the Ticket program can save $18,363 for every additional SSDI beneficiary and $12,049 for every SSI beneficiary that it assists to exit cash benefits. The weighted average savings per additional exit would be $17,669.

The potential savings from the Ticket program depend on a wide variety of factors. A major challenge in estimating net savings is that it can take years for all the Ticket-induced benefit reductions and payments to occur. Benefit reductions often come well after beneficiaries start working. We estimate that 30 percent of beneficiaries who exit cash benefits for work will remain off cash benefits for 10 years and that most people who return to cash benefits do so in the first two years after exit. These estimates are based on the actual experience of a 1996 cohort of new beneficiaries we followed for 10 years and Ticket participants from a cohort in 2002 we followed for 4 years. The program could generate a substantial payoff even if it merely slowed the rate at which former beneficiaries return to our rolls, even if the same percentage of beneficiaries ultimately return.

We have examined how the return on investment varies under a reasonable range of assumptions and find the Ticket program would cover its costs if it induced a relatively small number of new exits. At an average savings of $17,669, the Ticket program would have to induce between 2,000 and 3,000 additional beneficiary exits to generate enough savings to cover the approximately $46 million in annual costs for the Ticket program.

We currently cannot answer the question of self-financing definitively. To answer this question, we need to know the number of new induced exits (i.e., beneficiaries who would not have exited absent the Ticket program), not just the number of total exits of beneficiaries participating in the Ticket program. We are continuing our research to estimate the net effect of the program. According to our research, we need only a small number of new exits to cover Ticket program costs. Therefore, given the small number of new exits required relative to the size of the program, and the total number of exits we have seen annually under the Ticket program, we believe that it is possible that the program is already covering its costs. We also know that small decreases in the proportion of beneficiaries who return and small increases in the length of time beneficiaries remain working can have substantial effects on whether the Ticket program is self-financing.

We based our analysis on the draft Ticket program evaluation report prepared by Mathematica Policy Research, Inc. (MPR). There are two items that we did not explicitly address in the analysis. The first is that the analysis does not include the costs of suspending medical CDRs for ticket holders. The second is that the analysis does not include potential Medicare savings that may accrue for beneficiaries who have their Medicare benefits terminated after the extended Medicare period because of their work activity induced by the Ticket program. These two effects are extremely difficult to estimate. MPR argues that the effect of CDR suspensions on their analysis is likely to be small, based on the number of CDR cessations each year. MPR used a ten-year horizon for their savings calculations. With extended Medicare coverage at nearly eight years, savings are only possible for these last two years for those beneficiaries who remain off of cash benefits a the end of this period. The net effect of omitting these two items is likely to be either a relatively small program cost or a relatively small program savings. We assume that they are negligible for the purposes of the analysis.

We are conducting a final review of the MPR draft report, and it should be available on our website by the end of the calendar year.

12. Overpayments waste taxpayer dollars and have a debilitating effect on those who attempt to work. Please update the Subcommittees on your efforts to reduce overpayments resulting from work.

The potential for an overpayment may discourage some beneficiaries from working, and we have taken several steps to handle our work CDRs more efficiently. For example, we allocated additional staff resources to analyze work reports and to conduct work CDRs, and we are targeting the cases with the oldest work reports – those over 365 days old. We are also shifting work to offices with more capacity to conduct CDRs.

Furthermore, we have established internal goals for handling work CDRs. When we receive a report of work directly from a beneficiary, our goal is to screen that report within 30 days to determine if the work activity is likely to affect benefit payments or entitlement. If the work activity will affect benefits or entitlement, we assign the case for review, with a goal of completing the case review and handling within 270 days. Although we instruct beneficiaries to report any work activity, most do not. In those cases, our goal is to process 95 percent of the work alerts we receive within one year of receipt. It is important to remember that SSDI beneficiaries have a nine-month TWP before their monthly benefits will be suspended if their earnings are at the SGA level. Therefore, we cannot always take immediate action when someone reports work activity.

We also developed a statistical predictive model that identifies beneficiaries who are at risk of receiving high earnings-related overpayments. We use the predictive model to help us prioritize the alerts that we receive on SSDI beneficiaries with unreported earnings so we can work high-risk cases first and reduce the dollar amount of work-related overpayments. We began testing this model in October 2010 in our New York Region, and we expanded the pilot to include our Kansas City Region and our Office of Central Operations, which covers over 50 percent of the CDR workload.

We are also working to coordinate two earnings related processes: our benefit recomputation process and our process to identify SSDI beneficiaries with unreported earnings. We hope to prioritize the workloads so we can review cases with unreported earnings before we compute and release any benefit increase.

Finally, we are developing new policies and procedures that will streamline work CDR case processing, resulting in faster decisions and reduced overpayments. Examples include:

- Revising our work activity reports and streamline follow-up procedures;
- Eliminating the signature requirement on the work activity reports;
- Minimizing documentation for work activity that is obviously not SGA; and
- Updating our work CDR instructions to improve coordination between our field offices and processing centers.

If we receive authorization to conduct the WISP demonstration project, we would use it to test important improvements in our return-to-work rules, subject to rigorous evaluation protocols. WISP would eliminate current barriers to employment by simplifying the treatment of beneficiaries' earnings and reduce overpayments resulting from work.

13. **In their testimony, the Council of State Administrators of Vocational Rehabilitation reports $7.00 in savings for every $1.00 reimbursed to Vocational Rehabilitation (VR). Has the SSA explored ways to further increase savings through this program by reimbursing VR after longer periods of work above substantial gainful activity? For example, reimbursing VR after a period of 15 months, when the individual would have completed their 9-month trial work period and 3-month grace period, and no longer received cash benefits for 5 months?**

We have not studied the effect of reimbursing VR after longer periods of work, but we would be willing to explore this issue. Please note that absent a statutory change, we cannot implement the suggested reimbursement changes.

Enclosures (2)

Enclosure for Question 7e

PROPOSED WIPA BENCHMARKS REPORT For XX/XX/XXXX to XX/XX/XXXX

Total Enrolled in I&R During Date Range: XX,XXX Total Enrolled in WIPA During Date Range: XX,XXX

Section	Beneficiary Activity in WIPA/ETO	Population	Definition (how we will program the numbers)	Number	Percent	Benchmark
	1.1 I&R Assessment	Total enrolled in I&R	Number of I&R Enrollees (reference total above) who had an I&R assessment in WIPA/ETO		90%	90/100
	1.2 Enrolled into WIPA Program	Total enrolled in I&R	Number of WIPA Enrollees with an I&R assessment enrolled in WIPA Services		75%	75/100
	2.1 WIPA Baseline Assessment	Total enrolled in WIPA	Number of WIPA Enrollees with a WIPA baseline assessment (regardless of BS&A or WIPs)		100%	75/75
	2.2 WIPA Level 2 Services	Total enrolled in WIPA	Number of WIPA Enrollees with a Baseline Assessment and BS&A - (regardless of WIPs)		60%	45/75
	2.3 WIPA Level 3 Services	Total enrolled in WIPA	Number of WIPA Enrollees with a Baseline Assessment , BS&A and WIP		40%	30/75
	3.1 Time from WIPA Enrollment to Completion of the BS&A	Total enrolled in WIPA with BS&A	Number of WIPA Enrollees with a BS&A completed within 42 days of WIPA Enrollment		80%	36/45
	3.2 WIP Implementation Services	Total with WIPs older than 182 days	Number of efforts for WIPA enrollees with WIPs within 182 days of WIP development		5	5 efforts
	3.3 Mean Number of Efforts	Total enrolled in WIPA longer than 182 days	Average number of efforts per beneficiary within 182 days of WIPA enrollment		4	4 efforts
Section 4 Total Beneficiaries Served						
	4.1 Total Beneficiaries Served		Number served per SSA WIPA funded CWIC FTE		110	
Section 5 Annual Performance Indicator to Be Measured by SSA						
	5.1 Total Beneficiaries Served	Total enrolled in WIPA 18 months or longer	Percentage of WIPA enrollees who achieved sustained employment of 3 months or longer and cessation of benefits		10%	

Assume WIPA has 100 I&R enrollees

WIPA: Work Incentives Planning and Assistance
I&R: Information and Referral
ETO: Efforts to Outcomes
BS&A: Benefit Summary and Analysis
WIP: Work Incentives Plan
CWIC: Community Work Incentive Coordinator
FTE: Full-time Equivalent

Enclosure for Question 8

Employment Network (EN) Performance Standards

We will evaluate all ENs that have been under contract for the full 12-month review period. For those ENs that meet the preceding condition, we will evaluate EN performance at the end of each 12-month review period against specified service and outcome performance criteria.
We will calculate six levels of performance based on the following criteria:

Rating	Criteria
Individual Work Plan (IWP) Certification	Percentage of cases on which the EN substantially completed the services it committed to in the IWP.
Ongoing Employment Support Certification	Percentage of cases on which the EN substantially completed the ongoing employment support services to which it committed.
Job Placement	Percentage of beneficiaries assigned to the EN who started working at or above the trial work level within 9 months of ticket assignment.
Employment Results	Percentage of beneficiaries assigned to the EN who either: • Achieved their timely progress benchmarks; or • Retained employment above the substantial gainful activity level for 3 months.
Customer Satisfaction	Average customer satisfaction rating of beneficiaries assigned to the EN.
Financial Independence	Percentage of beneficiaries assigned to the EN who had 12-month earnings above the blind SGA level, which is about 180 percent of the Federal poverty level.

Questions for the Record
For the January 24, 2012 Hearing
On Combating Disability Waste, Fraud, and Abuse

1. **In August, Congress authorized $896 million in additional funds for FY 2012 so that the agency could perform Continuing Disability Reviews (CDRs) and redeterminations. In December, Congress appropriated $758 million for this work. In response to questions for the record on September 16, 2011, you stated that you had a backlog of 1.4 million medical CDRs, but that you anticipated that with the appropriated money "we would be able to catch up on Title II CDRs by 2016." As you were able to make this projection last September, you must have had projections and plans on the drawing board to get started on the integrity work. Has the money been allocated to the front lines to get this work started? The growing backlogs of CDRs, including full medical CDRs, needs to be reduced as soon as possible. Please submit to this Subcommittee a full detailed plan for how this will be accomplished.**

   The Administration strongly supports the program integrity cap adjustments authorized by the Budget Control Act, which would put us on a ten-year path to essentially eliminate the backlog in program integrity reviews. In fact, the President's 2013 Budget urges Congress to appropriate the remaining $140 million in program integrity funding authorized under the BCA for 2012, which would save taxpayers an additional estimated $800 million.

   We plan to complete 435,000 full medical CDRs with our fiscal year (FY) 2012 appropriated program integrity funding--about 90,000 more than we completed in FY 2011. We began ramping up our program integrity work at the beginning of the fiscal year; we have allocated the necessary resources and are on track to achieve our CDR and Supplemental Security Income (SSI) redetermination targets for the appropriated funding level.

   While we will complete significantly more full medical CDRs than we did last year, we will not be able to complete as many as we would have with the level of funding authorized in the *Budget Control Act of 2011* (BCA). If we had received full BCA funding-- $896 million for FY 2012--we would have been able to complete a projected 568,000 full medical CDRs.

   Adequate funding is critical to the reduction of the CDR backlog. The BCA allows increases to the Government's annual spending caps through FY 2021 for program integrity spending, and these increases would allow us to complete substantially more CDRs at considerable savings to the taxpayers. It is important to understand that the same people who handle CDRs also handle initial disability claims. Therefore, we need an adequate number of trained employees to complete both workloads. If we do not receive increased funding for our program integrity work, it will be virtually impossible to reduce the CDR backlog.

   The FY 2013 President's Budget includes $1.024 billion for our program integrity work, consistent with the BCA. If we receive this funding on a timely basis, we plan to complete 650,000 full medical CDRs--about 215,000 more than we expect to complete in FY 2012. In

FY 2013, we estimate that every dollar spent on CDRs will yield about $9 in program savings over 10 years, including Medicare and Medicaid program effects.

Our Office of the Chief Actuary has updated its estimates based on our current CDR review and profile processes. If we received the full amounts authorized under BCA, we could become current on title II medical CDRs in 2014, two years earlier than our prior estimate.

2. **How aware are agency personnel of the Cooperative Disability Investigation program and its successes? How does the agency make sure that front line employees know about their responsibilities to find and report fraud?**

We promote awareness of the Cooperative Disability Investigations (CDI) program in several different ways. The CDI units conduct regular training with our field offices and the disability determination services (DDS) to make them aware of the CDI program and to instruct them on how to report fraud. To raise awareness of the CDI program and its accomplishments, we distribute to our field offices a monthly fact sheet that the Office of the Inspector General (OIG) publishes. Due to these efforts, the CDI program received 6,208 allegations of potential fraud in FY 2011. Of this number, approximately 64 percent came from the DDSs, 23 percent from our field office employees, and 13 percent from other sources, such as our Office of Disability Adjudication and Review, OIG, and the fraud hotline.

Our frontline employees are often the first to identify potential fraud. Field office employees routinely assess the authenticity of evidentiary documents, scrutinize statements made by applicants, use our databases and Internet tools to find discrepancies, and follow up on complaints or tips from the public.

3. **Your own policies require CDRs for 60 percent of beneficiaries within three years. What kinds of disabilities are included in this 3-year category?**

We set the three-year review, otherwise known as the Medical Improvement Possible (MIP) diary, for adult beneficiaries whose medical conditions may improve and allow them to be able to work. While the timeframe for a review depends on individual case facts, generally, the majority of beneficiaries receive a MIP diary. Although MIP diaries have historically comprised 60 percent of our diaries, our policy does not require that 60 percent of beneficiaries receive a review in three years. Examples of impairments that can fall within this category include heart failure and severe diabetes with end organ damage. By contrast, we set a seven-year review for impairments where medical improvement is not expected due to the nature of the impairment(s), such as some intellectual disabilities. Regardless of when we schedule the review, we will need the full level of program integrity funding authorized under the BCA to keep up with all of the cases that are due for a medical review.

4. **I understand about five percent of beneficiaries are scheduled for a review in a 6 to 18 month time period; this is the medical improvement expected category. What conditions are scheduled for reviews within these timeframes?**

   We set the Medical Improvement Expected (MIE) diary for adult beneficiaries whose medical conditions will probably improve and allow them to be able to work. Whether we set an MIE diary depends on individual case facts. Examples of impairments that can fall within this category include traumatic injuries and severe bone fracture.

5. **In the FY 2012 Annual Performance Plan, your message states, "We will use technology to reduce our back logs, improve service, and target our program integrity efforts. For example, we are capitalizing on advances in video technology and electronic processes." Can you elaborate on what kinds of "electronic processes" are being utilized, and how they have helped improve program integrity efforts?**

   We use an array of electronic processes to improve our program integrity efforts. For example, we created the Access to Financial Institutions (AFI) electronic process to automatically verify financial account balances of claimants and recipients during the SSI claims and redeterminations process. We developed AFI to address the leading cause of SSI overpayment errors--excess resources in financial accounts. We also use an electronic process to track all allegations of benefit misuse by representative payees.

   We have much more work than we can complete in one year. Technology has allowed us to develop tools to prioritize our program integrity work to focus on the cases that give us the greatest return for our limited administrative dollars. We use these tools to select the most cost-effective medical and work CDRs, as well as the SSI redeterminations we should complete. As a result of these types of tools, we expect that the SSI redeterminations that we conduct in FY 2012 will save about $3.2 billion in total lifetime SSI overpayments compared to only $1.8 billion in savings if we had selected the cases randomly.

   Moreover, we strive to provide the DDSs with the tools they need to quickly and accurately decide disability cases to help ensure that we pay disability benefits to those applicants who qualify. Our Compassionate Allowances initiative allows us to identify claimants who are clearly disabled because the nature of their disease or condition meets the statutory standard for disability. With the help of sophisticated new information technology, we can quickly identify potential Compassionate Allowances and then swiftly make decisions. Our Quick Disability Determination initiative 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.

   We are developing other new electronic tools. For example, we are developing the Veterans Affairs (VA) Supplemental Security Record Pension Calculation for the *Medicare Modernization Act*, which will help prevent improper payments by ensuring veterans receiving VA pensions who apply for Part D Low Income Subsidy receive the most advantageous subsidy amount possible.

6. **Why has the number of CDRs performed by the SSA declined recently? How significant has the decline been? What are the lost savings as a result?**

We have steadily increased the number of full medical CDRs we complete every year since FY 2007. In FY 2012, we are completing more than double the number of full medical CDRS we completed in FY 2007. We have saved significantly more program dollars by completing more CDRs. Sustained, adequate funding is critical for us to continue this cost-effective work, because the same employees who do this work also handle initial claims and other program integrity activities.

7. **What are the future projected numbers of CDRs the Social Security Administration (SSA) expects to schedule and complete?**

In FY 2012, we expect to complete 435,000 full medical CDRs and 850,000 mailer CDRs.

The FY 2013 President's Budget includes $1.024 billion for program integrity work, consistent with the BCA. With funding at this level, we plan to complete 650,000 full medical CDRs. In FY 2013, we estimate that every dollar spent on CDRs will yield about $9 in program savings over 10 years, including Medicare and Medicaid program effects.

8. **How does the SSA select which medical CDRs are conducted each year and the percentage that are mailers?**

The number of periodic CDRs we complete each year depends on the level of funding we receive. Our annual budget request includes the number and type of CDRs we plan to complete. For cases we initiate centrally, we use one of two methods. We send some cases to the DDSs for a full medical review; others we complete using the mailer process.

We decide whether to initiate a full medical review or send a mailer after identifying those cases with a higher likelihood of medical improvement. We send cases with a higher likelihood of medical improvement to the DDS for a full medical review. We send a mailer for those cases with a lower likelihood of medical improvement to obtain more information from beneficiaries; we evaluate the information we receive to determine if there is any indication of medical improvement. If there is, we send the case to the DDS for a full medical review. Otherwise, we do not initiate a full medical review, and we schedule the case for a future CDR.

9. **The Disability program provides an essential income safety net for those who cannot work. But we also know there are those receiving disability benefits who want to work and believe they can work. Given the increase in applications for benefits during the recession and with so few coming off the rolls is the disability insurance program becoming a long term unemployment program for these people?**

The changing age distribution of the population is the main driver of long-term Disability Insurance (DI) program growth. For example, the aging of the baby boom generation into more disability prone ages accounts for a large portion of the growth in DI awards, and that

growth has been predicted for many years. Increased labor force participation among women over the past decades, which has led to an increase in the proportion of the population who meet the DI program's coverage requirements, is another important factor in the growth of the DI program.

Prior to FY 2009, we received about 1.6 million title II initial disability claims each year. Since 2009, that level has increased dramatically. In FY 2011, we received nearly 2.1 million title II disability claims. The recession played an important role in the increased number of applications; people with disabilities tend to have a higher unemployment rate than others, and long unemployment spells can make it more difficult to re-enter the work force. In a recession, people with disabilities may apply for and receive DI benefits sooner than they would in normal economic times, which could result in receiving DI benefits for a slightly longer period. To the extent that the recession may have motivated people to file DI claims based on less severe impairments that typically would not meet the definition of disability, we would expect that the average probability of an allowance should go down. That trend is exactly what we have seen. During the recession, our allowance rates have dropped at the DDS and appeals levels.

10. The SSA Office of Inspector General was able to identify high dollar overpayments that the SSA missed just by looking at it a different way. What is the SSA going to do differently in the future to make sure high dollar overpayments are identified?

The Office of Management and Budget (OMB) requires us to report on high-dollar overpayments. We base the methodology we use to detect high-dollar overpayments on a statistically valid sample of Old-Age, Survivors, and Disability Insurance payments and SSI payments, from which we conduct our payment accuracy reviews (also known as Stewardship reviews). OMB has agreed that the manner in which we detect and report our high-dollar overpayments meets the requirements, as provided in Executive Order 13520. Every quarter, we review our Stewardship data to determine if we have identified any overpayments that meet the criteria of the Executive Order for high-dollar overpayments. To date, we have not found any high-dollar overpayments.

Not every overpayment is an improper payment. For example, we do not consider overpayments resulting from legal or policy requirements as improper payments. OMB recognizes that the Stewardship data do not account for this difference but agrees that using these data provide the most efficient method to meet the intent of the Executive Order.

SOCIAL SECURITY

The Commissioner

May 18, 2012

The Honorable Sam Johnson
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your letter of March 22, 2012 requesting additional information in order to complete the record for the hearing on our death records. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030 who is available to meet with your staff if requested.

Sincerely,

Michael J. Astrue

Enclosure

1. **It has been suggested that your current notification policy (related to someone's Social Security number being made public by mistake) violates the Privacy Act and the Office of Management and Budget's guidance. What is your response?**

   OMB guidance (M-07-16) provides that an agency should notify individuals when there is a reasonable risk of harm, but should avoid creating unnecessary concern or confusion when the risk level is low. We do not notify an individual unless we identify misuse. If we find a case of misuse, we will notify the affected individual immediately and offer credit monitoring or other appropriate identity theft protection services. However, since 2008 when we began reviewing persons erroneously listed on the DMF to look for patterns of misuse, we have not identified any cases of misuse.

   We are reviewing our policy to determine whether it strikes the right balance and is respectful of public perception. We expect to complete our review in 90-120 days. Not having to release death information to the public would largely resolve this issue with regard to the Death Master File.

2. **Your Inspector General has criticized the agency for not notifying the 14,000 living people who are erroneously put on the Death Master File (DMF) each year. I understand the Social Security Administration (SSA) has a contractor review these cases for patterns of possible misuse. Would you tell us more about that process? How much time does it take for the SSA to discover and remove the errors for those living from the DMF? If there are patterns of misuse would you then notify the individual directly? You mentioned during the hearing that you were reviewing your notification policy. When can we expect the results of your review?**

   We contract with ID Analytics, a leading identity risk management firm, to review the cases in which we have erroneously placed a living person on the DMF. ID Analytics operates the ID Network, a cross-industry collaboration of data sharing for the purpose of identity fraud prevention. ID Analytics examines risk events, primarily new account opening or account changes, for the likelihood that these events represent identity fraud. ID Analytics reviews these cases quarterly for a period of three years. To date, it has not identified any patterns of misuse. If it were to identify misuse, we would promptly notify individuals and offer credit monitoring.

   While we do not track how long it takes to identify an error on the DMF, we act quickly to correct an error when we discover it. We expect to complete our review in 90-120 days and will share the results with you.

3. **I understand the SSA offers a consent-based SSN verification system that includes death information. Would you tell us more about this system and your views regarding whether it could be a source for death information should Congress change the law to prevent the Death Master File from being made public?**

   Private companies and Federal, State, and local agencies pay to use our Consent Based Social Security Number Verification Service (CBSV) to verify Social Security numbers (SSN). In order to use CBSV, entities must have a properly signed consent form, and they may only use the verification results for the reason the client specifies.

   CBSV verifies whether a name/SSN combination matches data in our records. Each name/SSN combination submitted to CBSV is returned with a "yes" or "no" verification code, which indicates that the submission either does or does not match our records. If the name/SSN match and our records show that the SSN holder is deceased, the response includes the fact of death but not the date of death.

   We do not believe CBSV would be a satisfactory alternative to the DMF in most cases. Unlike the DMF, CBSV requires the consent of the Social Security number holder and provides only an indication of death, not the information most users want, such as date of death. In addition, CBSV is a one-time verification process. Users enter one name/SSN combination at a time. In contrast, the DMF is a database of death information, which can be run against the purchaser's own records.

4. **Under the Social Security Act, the SSA may give states death data to administer benefits "wholly funded by the state." In the case of state retirement benefits, the employees help fund the pension through their contributions. Since state retirement benefits are not "wholly" funded by the State, state benefit retirement agencies must obtain death records to administer their programs by purchasing the Death Master File. I don't think this was the intent of the law. What is your opinion?**

   Section 205(r)(3) of the Social Security Act provides that we may share our death information with Federal and State agencies to ensure proper payment of federally-funded benefits, while section 205(r)(4) states that we may provide our death information to States for their use in programs only if those programs are wholly funded by the States. By including "wholly," Congress left no discretion to share the full DMF with State agencies to administer programs that are funded by employees as well as State governments.

   However, State retirement systems should be able to get State deaths from their State department of vital records.

5. **Would you explain your policy of issuing new Social Security numbers (SSNs) to children whose identities have been compromised? Children usually have no wages so why not respect a parent's wishes to protect their child? How do you know that the number won't be used in the future for some harmful purpose? Does your agency at least flag the number as stolen in your verification processes?**

   In light of the increase in identity theft, we are currently reviewing our policy to ensure it is responsive, especially to children.

   Our current SSN policy tries to balance appropriate and necessary control over the issuance of SSNs with the need to address unique events that warrant a new number. We assign a new SSN when a person provides evidence that criminal or harmful misuse of the number has caused recent economic or personal hardship. We also advise the person that a new number may not solve all problems. Because of the widespread use of the SSN, the person may have difficulty transitioning to the new number with employers, banks, credit bureaus, and other entities. Even the SSNs of children who have no earnings may have already been shared with many entities, beginning with pediatricians and health insurance providers.

   Once we assign a new number, we refer the person to the Federal Trade Commission to request a fraud alert be placed on credit records. We also flag the old number in our records. Employers, State agencies issuing driver's licenses and identification cards, and CBSV users see this flag when they use our verification routines.

6. **Has the National Association for Public Health Statistics and Information Systems participated in the interagency working group? Further, when you contract with states for their death data, what kind of agreements are there? Please indicate the general terms of these agreements. Are all state agreements similar? Are there restrictions on the use and sharing of this data to other parties including other federal agencies?**

   To our knowledge, the National Association for Public Health Statistics and Information Systems has not participated in the OMB-led review of the policy behind the availability of death information.

   Our contractual agreements with the States to provide death information are based on the provisions of section 205(r) of the Social Security Act. These agreements outline the data we can exchange and its permissible uses, including rules for sharing the data. Each State contract contains the same language, regardless of whether the State participates in Electronic Death Registration (EDR), an initiative to automate the paperbound death registration process.

   Section 205(r) prohibits us from redisclosing death information provided to us by the States, except to Federal and State agencies that provide federally-funded benefits and States that administer benefit programs wholly funded by the State. Additionally, the law provides us with discretion to provide death information to Federal and State agencies for research and statistical purposes.

We have attached a blank copy of a State contract for your information.

7. **Social Security shares the death information in its internal databases with other agencies that also provide benefits, such as the Department of Veterans Affairs (VA). Do these agencies make this information available to the public? Do your data sharing agreements prevent these agencies sharing this information publically or with any other agency?**

   We share death information with Federal benefit-paying agencies following the computer matching and privacy protection requirements of the Privacy Act. These agreements prohibit agencies from redisclosing the data we send them.

8. **What would it cost to bring all remaining non-participating states into the Electronic Death Registration system?**

   We defer to the Department of Health and Human Services (HHS) with respect to the costs involved in the development of EDR systems.

9. **In considering potential solutions as to how we ensure that entities using the information contained on the Death Master File are still able to access the data, would there be a way for the SSA to work directly with the entities that have a need for the Death Master File to receive the information directly from Social Security rather than through a third party?**

   OMB has been working with us and the Departments of Treasury, Justice, and Defense to craft a legislative approach to limit the public availability of death information. The Administration has previously presented the specifications for a draft bill to Committee staff, and will soon formally submit that draft bill for the consideration of the Congress, which reflects our preferred balance between protection of personally identifying information (PII) and allowance of limited access with strict accountability. We look forward to working with the Committee on that draft bill. Please note that there is no benefit to SSA to share this information. We do so because FOIA requires it.

10. **I learned about a North Dakotan who is having a similar issue to some of the one's we've been discussing with the Death Master File. The person was notified for the second time of his wrongly reported death listing by the VA. The incorrect information regarding his death also made it onto the Internet. However, we did receive a notice from the VA about the error. I would like to know, if the VA can catch this kind of error, and then notify the affected individual, do you think the SSA could use a similar process so that the individual can take steps to protect their personal information?**

    We will contact the VA during our notification policy review to learn more about its breach notification processes. We will adopt any cost-effective measures to more quickly identify

errors on the DMF, without relying on self-reports. Early identification of these errors would limit PII exposure and lessen any hardship for affected individuals.

Attachment

Blank State contract

SOLICITATION/CONTRACT/ORDER FOR COMMERCIAL ITEMS
OFFEROR TO COMPLETE BLOCKS 12, 17, 23, 24, & 30

1. REQUISITION NUMBER	PAGE 1 OF

2. CONTRACT NO.	3. AWARD/EFFECTIVE DATE	4. ORDER NUMBER	5. SOLICITATION NUMBER	6. SOLICITATION ISSUE DATE

7. FOR SOLICITATION INFORMATION CALL:	a. NAME	b. TELEPHONE NUMBER *(No collect calls)*	8. OFFER DUE DATE/ LOCAL TIME

9. ISSUED BY	CODE	10. THIS ACQUISITION IS ☐ UNRESTRICTED OR ☐ SET ASIDE: % FOR:
		☐ SMALL BUSINESS ☐ HUBZONE SMALL BUSINESS ☐ SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS ☐ WOMEN-OWNED SMALL BUSINESS (WOSB) ELIGIBLE UNDER THE WOMEN-OWNED SMALL BUSINESS PROGRAM ☐ ECONOMICALLY DISADVANTAGED WOMEN-OWNED SMALL BUSINESS (EDWOSB) ☐ 8 (A) NAICS: SIZE STANDARD:

11. DELIVERY FOR FOB DESTINATION UNLESS BLOCK IS MARKED ☐ SEE SCHEDULE	12. DISCOUNT TERMS	☐ 13a. THIS CONTRACT IS A RATED ORDER UNDER DPAS (15 CFR 700)	13b. RATING 14. METHOD OF SOLICITATION ☐ RFQ ☐ IFB ☐ RFP

15. DELIVER TO	CODE	16. ADMINISTERED BY	CODE

17a. CONTRACTOR/ OFFEROR	CODE	FACILITY CODE	18a. PAYMENT WILL BE MADE BY	CODE

TELEPHONE NO.

☐ 17b. CHECK IF REMITTANCE IS DIFFERENT AND PUT SUCH ADDRESS IN OFFER	18b. SUBMIT INVOICES TO ADDRESS SHOWN IN BLOCK 18a UNLESS BLOCK BELOW IS CHECKED ☐ SEE ADDENDUM

19. ITEM NO.	20. SCHEDULE OF SUPPLIES/SERVICES	21. QUANTITY	22. UNIT	23. UNIT PRICE	24. AMOUNT
	(Use Reverse and/or Attach Additional Sheets as Necessary)				

25. ACCOUNTING AND APPROPRIATION DATA	26. TOTAL AWARD AMOUNT *(For Govt. Use Only)*

☐ 27a. SOLICITATION INCORPORATES BY REFERENCE FAR 52.212-1, 52.212-4. FAR 52.212-3 AND 52.212-5 ARE ATTACHED. ADDENDA ☐ ARE ☐ ARE NOT ATTACHED

☐ 27b. CONTRACT/PURCHASE ORDER INCORPORATES BY REFERENCE FAR 52.212-4. FAR 52.212-5 IS ATTACHED. ADDENDA ☐ ARE ☐ ARE NOT ATTACHED

☐ 28. CONTRACTOR IS REQUIRED TO SIGN THIS DOCUMENT AND RETURN ____ COPIES TO ISSUING OFFICE. CONTRACTOR AGREES TO FURNISH AND DELIVER ALL ITEMS SET FORTH OR OTHERWISE IDENTIFIED ABOVE AND ON ANY ADDITIONAL SHEETS SUBJECT TO THE TERMS AND CONDITIONS SPECIFIED	☐ 29. AWARD OF CONTRACT: REF. _____ OFFER DATED _____. YOUR OFFER ON SOLICITATION (BLOCK 5), INCLUDING ANY ADDITIONS OR CHANGES WHICH ARE SET FORTH HEREIN, IS ACCEPTED AS TO ITEMS:

30a. SIGNATURE OF OFFEROR/CONTRACTOR	31a. UNITED STATES OF AMERICA *(SIGNATURE OF CONTRACTING OFFICER)*

30b. NAME AND TITLE OF SIGNER *(Type or print)*	30c. DATE SIGNED	31b. NAME OF CONTRACTING OFFICER *(Type or print)*	31c. DATE SIGNED

19. ITEM NO.	20. SCHEDULE OF SUPPLIES/SERVICES	21. QUANTITY	22. UNIT	23. UNIT PRICE	24. AMOUNT

32a. QUANTITY IN COLUMN 21 HAS BEEN

☐ RECEIVED ☐ INSPECTED ☐ ACCEPTED, AND CONFORMS TO THE CONTRACT, EXCEPT AS NOTED: _____

32b. SIGNATURE OF AUTHORIZED GOVERNMENT REPRESENTATIVE	32c. DATE	32d. PRINTED NAME AND TITLE OF AUTHORIZED GOVERNMENT REPRESENTATIVE

32e. MAILING ADDRESS OF AUTHORIZED GOVERNMENT REPRESENTATIVE	32f. TELPHONE NUMBER OF AUTHORZED GOVERNMENT REPRESENTATIVE
	32g. E-MAIL OF AUTHORIZED GOVERNMENT REPRESENTATIVE

33. SHIP NUMBER ☐ PARTIAL ☐ FINAL	34. VOUCHER NUMBER	35. AMOUNT VERIFIED CORRECT FOR	36. PAYMENT ☐ COMPLETE ☐ PARTIAL ☐ FINAL	37. CHECK NUMBER

38. S/R ACCOUNT NO.	39. S/R VOUCHER NUMBER	40. PAID BY

41a. I CERTIFY THIS ACCOUNT IS CORRECT AND PROPER FOR PAYMENT		42a. RECEIVED BY *(Print)*	
41b. SIGNATURE AND TITLE OF CERTIFYING OFFICER	41c. DATE	42b. RECEIVED AT *(Location)*	
		42c. DATE REC'D *(YY/MM/DD)*	42d. TOTAL CONTAINERS

SOCIAL SECURITY

The Commissioner

JUN - 7 2012

The Honorable Sam Johnson
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your May 3, 2012 letter requesting additional information to complete the record for the hearing on disability decisions. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

Michael J. Astrue

Enclosure

Congress of the United States
House of Representatives
COMMITTEE ON WAYS AND MEANS
WASHINGTON, DC 20515

SUBCOMMITTEE ON SOCIAL SECURITY

May 3, 2012

The Honorable Michael J. Astrue
Commissioner of Social Security
Social Security Administration
6401 Security Boulevard
Woodlawn, MD 21207

Dear Commissioner Astrue:

Thank you for your testimony before the Committee on Ways and Means Subcommittee on Social Security at the March 20, 2012 hearing on deciding who is disabled. In order to complete our hearing record, we would appreciate your response to the following questions:

1. The State responsibility for initial disability decisions was established by the Social Security Act Amendments of 1954. Given the challenging fiscal times at the state level do you worry that States have an incentive to award federal benefits to protect their own benefit programs? If not, how can you be sure that these initial decisions are being made objectively and accurately?

2. I understand there are DDS performance standards in regulations. The only stated performance measures are accuracy and processing time. The current minimal acceptable level for processing of disability insurance claims is 49.5 days. Given the average DDS processing time is over 100 days, are you planning on updating these regulations and will you include other standards to ensure a uniform national program?

3. Dr. Maestas discussed variations among DDS examiners that lead to inconsistent outcomes for beneficiaries. She finds that 5 percent of examiners have award rates of more than 12 percent higher or lower than the average. Have you reviewed outlier examiners across the State DDSs? If not, do you have plans to do so?

4. If a claimant's condition does not meet or equal the listings, the next step is an assessment of the claimant's remaining ability to function. How does an examiner or medical consultant assess someone's function? How subjective is that assessment?

5. At the hearing, Dr. Chan discussed the work you are doing with the National Institutes of Health to build a computer adaptive test that can help assess function. What can you tell us about this research, its impact on deciding disability in the future, and the timing of when such an assessment tool might be ready for implementation?

6. Consistent training can go a long way to creating consistent outcomes. In an Inspector General report on training in the DDS released on March 14, 2012, the IG found that State offices were supplementing the Social Security Administration's (SSA) training resources, and in some cases creating their own training materials for the same topics. That means Social Security is paying twice for some training. How does Social Security plan to address these findings and ensure a single presentation point for the SSA policy and practice in making disability decisions?

7. It seems like your efforts implementing health IT will significantly reduce wait times for initial decisions. How much have wait times been reduced in the pilot sites? What challenges are you facing?

8. How many continuing disability reviews have been performed so far this fiscal year? How many of those reviews are full medical reviews?

We would appreciate your responses to these questions by ***May 17, 2012***. Please send your response to the attention of Kim Hildred, Staff Director, Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, B-317 Rayburn House Office Building, Washington, DC 20515. In addition to a hard copy, please submit an electronic copy of your response in Microsoft Word format to jessica.cameron@mail.house.gov.

Thank you for taking the time to answer these questions for the record. If you have any questions concerning this request, you may reach Kim at (202) 225-9263.

Sincerely,

SAM JOHNSON
Chairman

Questions for the Record
For the March 20, 2012 Hearing
On Disability Decisions

Questions from Chairman Johnson

1. **The State responsibility for initial disability decisions was established by the Social Security Act Amendments of 1954. Given the challenging fiscal times at the State level do you worry that States have an incentive to award federal benefits to protect their own benefit programs? If not, how can you be sure that these initial decisions are being made objectively and accurately?**

   The State disability determination services (DDS) must evaluate disability claims based on our disability program policies and regulations. We have no evidence that State fiscal issues affect these determinations. In fact, during the recent economic downturn, our allowance rates for initial claims and reconsiderations have decreased.

   We use the statutorily required pre-effectuation review process to conduct a State-level quality review of 50 percent of DDS allowances. Moreover, we routinely conduct performance accuracy reviews on a sample of cases adjudicated by the States to ensure that DDS decisions are objective and accurate.

2. **I understand there are DDS performance standards in regulations. The only stated performance measures are accuracy and processing time. The current minimal acceptable level for processing of disability insurance claims is 49.5 days. Given the average DDS processing time is over 100 days, are you planning on updating these regulations and will you include other standards to ensure a uniform national program?**

   We are currently reviewing these regulations to determine whether there are changes that would help us ensure a uniform national program.

3. **Dr. Maestas discussed variations among DDS examiners that lead to inconsistent outcomes for beneficiaries. She finds that 5 percent of examiners have award rates of more than 12 percent higher or lower than the average. Have you reviewed outlier examiners across the State DDSs? If not, do you have plans to do so?**

   We do not review outlier examiners across State DDSs, and we do not have plans to do so. While we do not focus on decisions from specific examiners, we do conduct regular accuracy reviews on a sample of cases from each State to monitor and ensure the accuracy of DDS disability determinations.

   Every fiscal year (FY) we set a goal for the accuracy rate of initial disability determinations, track that accuracy rate, and publish our performance in our annual Performance and Accountability Report. Each year since FY 2007, the DDSs have met our annual accuracy goals.

4. If a claimant's condition does not meet or equal the listings, the next step is an assessment of the claimant's remaining ability to function. How does an examiner or medical consultant assess someone's function? How subjective is that assessment?

If a claimant's condition does not meet or equal the listings, we assess his or her residual functional capacity (RFC). An RFC assessment is a function-by-function assessment based upon all the relevant evidence of an individual's ability to do work-related activities. We arrive at an RFC by reviewing the claimant's medical record, his or her allegations of symptoms, opinion evidence from medical and nonmedical sources, and reports of the day-to-day function obtained from the claimant or other individuals who are familiar with the claimant.

In assessing RFC, we consider limitations and restrictions that result from medically determinable impairments (MDI). We also consider any available information about symptoms because subjective descriptions may indicate more severe limitations or restrictions than can be shown by objective medical evidence alone. However, we do not consider limitations or restrictions resulting from age, gender, body habitus (e.g., body type and stature), conditioning, or inherent strengths or predispositions not attributable to the claimant's MDI. While the RFC assessment is "subjective" in the sense that we base it on the individual facts of each claimant's case, we minimize this inherent subjectivity by applying consistent policy standards. Our electronic case analysis tool (e-CAT) helps ensure policy consistency. We currently use e-CAT in 72 percent of our initial claims. We recently mandated that all DDSs use e-CAT by October 2012.

5. At the hearing, Dr. Chan discussed the work you are doing with the National Institutes of Health to build a computer adaptive test that can help assess function. What can you tell us about this research, its impact on deciding disability in the future, and the timing of when such an assessment tool might be ready for implementation?

In 2008, we implemented an interagency agreement with the Rehabilitation Medicine Department at the National Institutes of Health's Clinical Research Center to analyze existing agency data and assess the feasibility of developing Computer Adaptive Testing (CAT) instruments.

CAT is a form of computer-based testing that tailors question selection based upon the claimant's ability level. It is similar in approach to standardized tests such as the Graduate Record Examination and Graduate Management Admission Test. Unlike a fixed-form test that asks the same questions of everyone, CAT instruments ask claimants and their providers only the most informative questions based on a person's response to previous questions. Using this approach allows the instrument to ask fewer questions (in total) because the selected questions are based on the individual's level of function. Using research and technology that is methodologically rigorous and defensible, we are developing the CAT instrument to obtain information on claimants' functional abilities in a manner that is systematic, comprehensive, and efficient.

To date, Boston University, which is a subcontractor, has developed questions for two of six categories of functioning to be included in the CAT instrument; these categories are mobility and interpersonal interactions. Additional domains include learning and applying knowledge, communication, self-care, and general tasks and demands. This scientific process will take four more years as each domain must be developed, calibrated, and validated to be scientifically defensible before we are able to integrate the CATs into our current disability process. Therefore, we expect to complete this instrument in 2016 and subsequently test it with claimants and providers.

6. **Consistent training can go a long way to creating consistent outcomes. In an Inspector General report on training in the DDS released on March 14, 2012, the IG found that State offices were supplementing the Social Security Administration's (SSA) training resources, and in some cases creating their own training materials for the same topics. That means Social Security is paying twice for some training. How does Social Security plan to address these findings and ensure a single presentation point for the SSA policy and practice in making disability decisions?**

We are taking several steps to improve DDS access to up-to-date and accurate training materials on disability policy and procedures. For example, we are enhancing our on-line tools to provide national access to all training materials, expanding the use of podcasts and video-on-demand to ensure accessibility to training, using trend analysis to identify specific training needs, and sharing best practices with disability-training officers at the regional and State levels.

We believe these steps will help us ensure consistency in our training and eliminate any redundancy.

7. **It seems like your efforts implementing health IT will significantly reduce wait times for initial decisions. How much have wait times been reduced in the pilot sites? What challenges are you facing?**

Health IT has the potential to transform our disability determination process. Developing the medical record via our current process is costly and time-consuming. Health IT automates this process and potentially provides a more complete medical record, thus improving the speed, accuracy, and efficiency of our decision-making.

While the actual volume of cases involving health IT data is still extremely small, we have seen a decrease in the time needed to adjudicate those cases. For the approximately 10,500 cases containing electronic data that we reviewed from October 2011 through April 2012, we experienced an approximately 20 percent reduction in total case processing time, which is the time from when a DDS receives an initial disability claim to when it decides that claim. The component time required to gather medical evidence dropped dramatically for these claims; a matter of seconds for electronic medical evidence compared to weeks or months for a typical paper-based medical evidence request. We look forward to the next stages of implementation of health IT standards that will advance our ability to have a uniform process and system to interact with the medical community.

8. How many continuing disability reviews have been performed so far this fiscal year? How many of those reviews are full medical reviews?

Through April 2012, we have completed 865,287 continuing disability reviews. Of these reviews, 338,655 are full medical reviews. We plan to complete 435,000 full medical CDRs with our fiscal year (FY) 2012 appropriated program integrity funding.

While we will complete significantly more full medical CDRs than we did last year, we will be unable to complete as many as we would have with the level of funding authorized in the *Budget Control Act of 2011* (BCA). If we had received full BCA funding-- $896 million for FY 2012--we would have been able to complete a projected 568,000 full medical CDRs.

SOCIAL SECURITY

The Commissioner

September 5, 2012

The Honorable Xavier Becerra
Ranking Member, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Becerra:

Thank you for your questions that Chairman Sam Johnson included in his June 15, 2012 letter requesting additional information in order to complete the record for the hearing on the state of our information technology. Enclosed you will find the answers to your questions and Mr. Johnson's.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030. Mr. Frey is available to meet with your staff if requested.

I am also sending this information to Chairman Sam Johnson.

Sincerely,

Michael J. Astrue

Enclosure

1. **The Information Resources Management plan identifies 10 "domains" but does not explain how each aligns specifically with the strategic plan. How do each of these domains specifically align with goals in the Agency Strategic Plan?**

   When considering potential information technology (IT) projects, we group proposals into portfolios that align to our Agency Strategic Plan (ASP) and include strategic alignment as a factor in our evaluation. In our Information Resources Management (IRM) plan, http://www.ssa.gov/irm/IRM_2012.pdf, we categorize our IT infrastructure that supports these projects into 10 domains, which include Data Management, Software/Applications, Business Intelligence, and Computing Platforms. While individual IT projects may align with a specific goal, these domains are foundational elements that support all ASP goals.

2. **Recently, Social Security launched the new online version of the Social Security Statement, as part of a new "My SSA" portal. The Statement is an important financial planning tool. Please explain more about how this portal works and how it relates to other online services now and in the future. Will the My SSA site eventually allow citizens to manage their business with Social Security in real time electronically, as recommended by the Social Security Advisory Board? How many people have viewed their Statement so far and what impact, if any, did this traffic have on your website?**

   To improve service and provide relief to our field offices, we have offered an ever-growing number of online services. MySSA's additional security requirements allow the public to do even more SSA business electronically because we can give information to the user instead of just receiving it. MySSA users must provide personal information and answer questions that only they are likely to know. Authenticated users are required to create a username and password that serve as their access to MySSA in the future. We decided to make the Statement our first MySSA application given its interest to so many Americans. So far, more than a million people have created an account to view their Statement. Resources permitting, in fiscal year 2013, we plan to expand MySSA services to allow users to change their address and direct deposit information and receive benefit verifications.

3. **Dr. Scherlis discussed the importance of having a baseline inventory of existing systems, to determine capabilities of current systems and identify potential vulnerabilities. Does Social Security have such a baseline assessment? If so, please provide a copy for the record. If not, why not?**

   We do maintain an inventory of our applications to document the capabilities of our current systems and help us identify potential vulnerabilities. We have attached a list with a short description of each application in our baseline inventory. For your information, we are sending a copy of our Application Information Report separately for security reasons.

4. **In a report requested by Social Security, the National Research Council of the National Academies assembled a committee of experts to perform a strategic assessment of Social Security's electronic services. This excellent report was published in 2007. Would you provide specific details regarding the steps Social Security has taken to implement each recommendation?**

   Since the National Research Council published its report in 2007, we have overhauled our electronic services, considering the recommendations in the report. First, we released our significantly improved Retirement Estimator, an easy-to-use benefit calculator that helps millions of people plan for retirement. We also completely redesigned our online benefit application, iClaim. Since we released iClaim in December 2008, we have increased the percentage of online benefit applications from single digits in most years prior to iClaim to 43 percent so far this year. iClaim has been essential in helping us keep pace with the significant increase in benefit applications due to the recession.

   Using public and employee feedback, lessons learned, and benchmarking with other organizations, we continue to improve and expand our online offerings, including the release of the first interactive online Spanish applications in the Federal government. In May, we released on our online Social Security Statement, the first application to use our MySSA portal. Depending on the availability of resources, we plan to expand the personalized services we offer.

   Public satisfaction scores demonstrate our success in overhauling our electronic services over the last five years. We currently have the three highest-rated electronic services in the Federal government—and five of the top six—as rated by the American Customer Satisfaction Index (ACSI), even outscoring the top private sector electronic services, Amazon and Google.

   We outline below how we addressed each of the nine specific recommendations from the National Research Council.

Recommendation 1:

The SSA should make an unambiguous, strategic commitment to electronic services as part of its long-term service delivery strategy, placing a central emphasis on electronic services that encompass timely and up-to-date information for users, partners, and beneficiaries.

Response to Recommendation 1:

We are committed to expanding and enhancing the quality and quantity of available electronic services. In FY 2011, we processed over 15 million personalized online transactions, reducing stress on our offices as we struggle to keep up with demand. Our May 2012 IRM plan reiterates our commitment to expand and enhance our online services, and it describes how our IT projects help us accomplish this goal. Furthermore, we are currently developing a Service Delivery Plan that will describe how we will use our resources to deliver services over the next four years and beyond, including how we will use and improve electronic tools.

Recommendation 2:

The SSA should carefully consider the ways in which the experiences and approaches of large-scale financial institutions— including state-of-the-practice electronic information and service delivery, metrics-guided improvement, and process transformation, among other approaches and solutions—might be relevant to the kinds of services that the agency is providing or may provide in the future.

Response to Recommendation 2:

We agree that we can learn from other organizations. In fact, we benchmarked with financial institutions, healthcare organizations, and other government agencies to implement best practices in authentication as we developed MySSA. We continue to collect information and advice from the financial community, other government agencies, and private IT research companies, such as Forrester, Gartner, the Info-Tech Research Group, the Corporate Executive Board, and the 451 Group. These collaborations, including lessons from the financial industry, provide valuable insight as we research and develop new service options, including developing mobile services.

Recommendation 3:

In order to move to the second phase of electronic services maturity, the SSA should create a focal point responsible for developing and managing electronic information and service delivery— including components such as Web content, online transactions, user interfaces, research, database systems and other key enabling technologies, and other facets of electronic service delivery that are currently dispersed throughout the SSA. This focal point should have sufficient resources to take on organization-wide responsibility for online services and should report directly to the SSA Commissioner or to a Deputy Commissioner.

Response to Recommendation 3:

The Office of Systems Electronic Services is our focal point for developing and managing electronic services. The office reports directly to the Deputy Commissioner for Systems and manages all aspects of our electronic service development and delivery. To support the efforts of this office, we have a cross-component eServices Governance Committee that oversees all activities related to our online services. This Committee has overseen the successful release of numerous online services, which routinely receive high customer satisfaction scores.

Recommendation 4:

As it makes decisions about future directions for its database technology, the SSA should give considerable weight to the implications of those decisions for the effectiveness and efficiency of current and future electronic service delivery and should be open to the introduction of new technologies.

Response to Recommendation 4:

We recognize the importance of defining a database architecture that uses newer technologies related to electronic services. We have made significant progress in replacing our databases that had used the Master Data Access Method (MADAM) with modern relational databases supported by IBM DB2 and Oracle, the industry-leading database management systems. We have converted three of our five master data files from MADAM to DB2 and will convert the fourth by the end of this year. We are currently planning to convert the fifth file. Our approach in migrating from MADAM to relational databases has allowed us to minimize the disruption to our offices during the conversion.

We are also making excellent progress in changing our computer code base that was dominated by older programming languages like COBOL and ALC to reflect a better balance of more modern code. Although we rely on older code, soon we will have more production computer programs written in JAVA language rather than COBOL. We will continue to take advantage of appropriate new technologies that can help us operate more efficiently and effectively.

Recommendation 5:

In continuing to develop its conversion strategy and long-term services strategy, the SSA should draw on a broad range of technical expertise—including but not limited to database software experts, software engineers, software security experts, financial services experts, large-scale commercial service providers, and systems architecture experts—and put systematic mechanisms in place so that it can hear and learn from outside advisers.

Response to Recommendation 5:

Please see our comments on Recommendation 2. We actively consult with independent technology and market research companies, such as Gartner and Forrester, to solicit independent and fact-based advice on existing and proposed technologies. We consult with IBM on database and emerging technologies to gain expertise related to industry standards and architectures. We use this expertise in our database conversion strategy. We also contract with Yevich, Lawson, and Associates on an annual basis to assist with our database conversion. This contract allows us to draw upon a broad range of technical expertise, including database development and conversions, software development, and systems capacity technologies.

Recommendation 6:

When evaluating new electronic service-delivery initiatives, the SSA should, when appropriate, seek to balance risks and rewards by recognizing such upside benefits from automation as cost reduction, fraud prevention, and customer satisfaction.

Response to Recommendation 6:

We carefully consider both risks and rewards as we evaluate new electronic service initiatives. We continue to implement our IT services incrementally. Our approach helps ensure that we realize value quickly and allows us to adapt to changing business and technology environments.

Recommendation 7:

The SSA should define and use metrics and measures to assess and improve its service delivery across all channels, including electronic services.

Response to Recommendation 7:

We communicate our metrics both internally and to the public in our Annual Performance Plan, www.socialsecurity.gov/budget/2012APP.pdf, and in our Performance and Accountability Reports, http://www.ssa.gov/finance/. We include performance measures related to our service, including several measures specific to our electronic services.

In addition to these metrics, we use ForeSee, a customer experience analytics firm founded at the University of Michigan's Ross School of Business, to help us gauge satisfaction with our electronic services. ForeSee administers the ACSI surveys to measure customer satisfaction with services. We use the survey data, which includes satisfaction scores and public comments, to improve our existing services and develop ideas for future services.

Recommendation 8:

The SSA should undertake to understand the identities, needs, and attitudes of its various user communities and should use that information to establish effective relationships and ongoing interactions with users, potential partners, and third parties. The SSA should explore partnering opportunities and identify the changes and initiatives that are necessary in order for it to enable appropriate interaction and cross-functionality with strategic partners and to support the exchange of data with other government agencies (both federal and state) while ensuring that appropriate security and privacy measures are in place.

Response to Recommendation 8:

Stakeholder input is critical to each stage of our eService development process. We routinely solicit public feedback through surveys, focus groups, and meetings with key external audiences. After we implement new services, we continue to engage our stakeholders by using feedback from ACSI surveys and conducting other surveys to improve our online services.

For example, input from users and external stakeholders was key to the success of two recent eService projects. We decided to offer our online services to the 35 million Americans who may prefer to conduct their business with us in Spanish. We gathered feedback from several Hispanic advocacy groups as we developed our Spanish language electronic services. These advocates provided valuable insight into how to best translate and design these services.

Before we implemented our new Internet authentication process for public access to our MySSA portal, we benchmarked with financial institutions, healthcare organizations and other government agencies to assess and implement best practices in authentication. We also conducted public focus group, tests, and surveys that helped us fine-tune usability and security. In addition, we sought the input and advice of numerous privacy experts and advocates for victims of identity theft and domestic violence. These discussions helped us design our authentication system with several features that provide additional protections for victims of domestic violence and identity theft.

With regard to the exchange of data with other Federal agencies, we have over 3,500 data exchanges with a variety of partners, including State and Federal benefit paying agencies. We routinely work with these agencies to ensure continued efficient and secure information exchanges.

Recommendation 9:

The SSA should embrace change as a constant. It should regularly evaluate emerging trends in such areas as technology (for example, database technologies) and business practices (for example, by learning from the experiences of financial institutions and moving toward the use of strategic partnerships for efficiency and effectiveness). It should also regularly evaluate the changing societal attitudes and expectations of its various user communities. The SSA should also institutionalize the formulation of strategies for addressing these trends.

Response to Recommendation 9:

We release new software and make extensive adjustments to our IT environment weekly. We continually evaluate trends in business practices and contract with private sector experts to gain insight into future technologies and customer support trends. As referenced earlier, we have learned valuable lessons from the experiences of the financial industry in adopting mobile technology. We will also continue to evaluate the expectations of our user communities. We already have in place numerous methods to gather input from the public, advocacy groups, and other third parties.

Our Compassionate Allowances and Quick Disability Determination processes are examples of how technology is helping us make faster and more accurate decisions. We continue to take advantage of Health IT, which has the ability to dramatically improve service.

We face a challenging budgetary environment and must make difficult choices between possible new investments. Therefore, we implement new technologies based on their business cases.

5. **In the Information Resources Management plan, Social Security's Hardy-Apfel Fellows program is touted as a way "to bring in IT talent from top graduate schools." How many Hardy-Apfel fellows have been hired and retained to date? Please provide the number hired in each year for the past 5 years, and the number from each hiring class currently working at Social Security. How do you recruit innovative technology experts and keep them?**

We began recruiting for the Hardy-Apfel IT Fellows program in 2008, and we have hired 17 participants to date. Hardy-Apfel is a small prestigious program selecting top IT talent to work on key Agency projects. The program is highly competitive, designed to recruit participants from Master's program universities that have top-ranked computer science programs. Recruitment efforts have successfully attracted 326 candidates. Of those candidates, 106 applied for the program.

Our recruiters attend universities career fairs and work directly with school career centers to inform qualified candidates about this program. Our nationwide recruitments efforts have included visits to:

Brown University
University of California Los Angeles
Georgia Institute of Technology
University of Maryland College Park
Massachusetts Institute of Technology
University of Texas at Austin
Carnegie Mellon University
Cornell University
Johns Hopkins University
Stanford University
University of Illinois at Urbana

Among the 17 Fellows hired, 14 remain in the agency. Consequently, the retention rate for the program is eighty-two percent. Below is a breakout of the number of Fellows recruited and retained:

- Recruitment year 2008-2009: retained 2 of the 4 hires.
- Recruitment year 2009-2010: retained 4 of the 5 hires.
- Recruitment year 2010-2011: retained all 3 hires.
- Recruitment year 2011-2012: retained all 5 hires.

We recruit and retain innovative technology experts by offering a flexible, high-level program in which the Hardy-Apfel Fellows can develop new fields of study or continue to pursue their current areas of interest. These Fellows realize that working at SSA gives them the opportunity to advance the information technology systems, programs, and policies of a large Government agency that touches the lives of nearly all Americans. They have the opportunity to work on key agency projects and to meet regularly with agency executives.

6. **In the Information Resources Management plan, the IT Skills Inventory is discussed. Is expertise regarding cloud computing and big data included in the IT Skills Inventory? If not, why not? If so, does Social Security have sufficient staff with these skills to meet its needs now and in the future? If not, how does Social Security plan to recruit individuals with these skills?**

   The technological aspects of cloud computing and big data are skill sets that our IT employees possess. We continue to train our IT staff to maintain and update their skills so they can address the changes in technology. We have not identified sets of new skills necessary to support cloud computing and big data that are separate and distinct from the IT skills already included in our IT Skills Inventory. To the extent that we identify the need for these core skill sets in the future, we will incorporate them into our IT Skills Inventory recruiting strategies and objectives. If the design and implementation of cloud and big data environments require highly specialized experience, we can engage consultants with that expertise to provide advice and train our existing staff.

7. **In recent years, the number of online services offered by Social Security has grown. What online services can the public expect from Social Security next? How do you decide what services to provide online? How long does it take to launch an online service?**

   Our next online service will provide real time access to the benefit verification. In fiscal year 2011, our front line employees manually processed 7.4 million requests for benefit verifications.

   During our IT planning process, we define and prioritize the IT initiatives necessary to accomplish our strategic goals and objectives. We consider many factors, such as our available resources, the expected service usage, effect on our local offices, improvement to the user experience and security, and overall return on investment. Every online service is unique. The time needed to launch a new service depends on its size, complexity, and the availability of adequate resources.

8. Social Security has top scores on some of its online applications in terms of customer satisfaction. But the two disability-focused sites, the application for benefits and applications for appealing a disability denial, do not score as well. In fact, the appeals application site is the second lowest scoring of all Social Security sites. Why? What changes are being made to these sites to ensure those applying for disability benefits receive the same high quality online experience that retirees do?

Our easy-to-use online application, iClaim, has been very successful. In FY 2009, we rolled out the first phase of iClaim, and we immediately saw a significant increase in Internet disability claims, even though we did not market the service to disability applicants. Our numbers continue to increase. In FY 2011, more than one million disability applicants (33 percent of the total) filed online, almost quadrupling the volume from the year before iClaim. To date in FY 2012, 38 percent of disability applicants filed online.

Last June, our Office of the Inspector General completed a review of the level of service provided to applicants filing for disability benefits using iClaim. This review, initiated at the request of Congress, found that 91 percent of survey respondents "...found their overall experience filing the iClaim (disability) application online to be excellent, very good, or good."

The complexity of the disability rules makes streamlining the online claim process more challenging, but we are making progress. In June we began capturing electronic signatures for medical authorization and allowing users to upload supporting files directly into our disability system. Over the next several years, we will be making other improvements depending on available funding.

We also used the ACSI customer satisfaction information for the Internet disability appeal (iAppeals) to help us identify areas for improvement. Earlier in FY 2012, we released an improved version of this application. Some of the changes included:

- providing tips on how to navigate the site;
- reducing the number of informational pages and placing key information behind links for easy access;
- clarifying instructional language;
- reducing the number of unnecessary screens;
- creating a new "Welcome Page" with a look and feel similar to our newer online applications.

We are currently evaluating recent ACSI survey results to further improve the iAppeals application.

9. **The Information Resources Management plan runs through fiscal year 2016. What types of planning is Social Security doing outside of the 5 year window? In his testimony, Dr. Scherlis recommended planning for potential changes to IT systems over five to ten years. Do you agree? If not, why not?**

   We base our IT guiding principles, which we describe in our IRM plan, on systematically modernizing our infrastructure using sound and viable technologies. Given the importance of our programs, we cannot afford to be captivated by the promise of new technologies before they are mature and cost effective to implement. Although we agree with Dr. Scherlis that IT strategic planning must be future looking, we believe that our 5-year planning horizon is appropriate. The unpredictability of our budget and the current annual budget planning and execution cycles make it difficult to plan beyond this length of time. We do, however, monitor emerging technologies.

10. **In his testimony, Dr. Scherlis discussed the potential of "big data" and described it as "computing techniques that enable rapid analysis and manipulation of vast quantities of data to turn it into actionable information." Is Social Security using this technology to better manage its programs? If not, why not? Are you planning to use it in the future?**

    In 2010, we began researching innovative architectural solutions to ensure the security and integrity of our rapidly expanding volume of data. As a result, we developed a proposal for a target architecture that enables the integrated capture, management, and analysis of events and large-scale data, or "big data." We refined this target architecture in 2011, and we are now using it as a strategic roadmap to identify, evaluate, and test potential technical solutions. In 2012, we are working with consultants to identify the strategies and data analytics that will leverage "big data" to enhance agency services.

11. **(From Mr. Johnson) For nearly a decade (FY2001-2011), Social Security stockpiled over $1 billion of its unspent appropriated funds in the Information Technology (IT) Fund. Congress had permitted Social Security to roll money into the fund for acquisition and maintenance of automated data processing and telecommunications hardware and software as well as support services and related contractual services. Social Security did not use the money in spite of appeals to Congress regarding its urgent IT needs. When the buildup of funds was discovered, Appropriators, on a bipartisan, bicameral basis, rescinded $275 million and required Social Security to draw down the fund. After the rescission, the IT fund had nearly $600 million remaining. Why did Social Security not use the IT fund to make timely maintenance and appropriate IT upgrades to protect the taxpayers' investment in the agency's IT system? Please provide specific details as to how IT funds have been spent since the $275 million was rescinded.**

These funds are a closely monitored, transparent part of our budget that we have used to help us handle increasing workloads. Our ability to transfer unobligated administrative funds to our Information Technology Systems (ITS) account is a funding mechanism Congress specifically authorized. We must justify to OMB any transfer of unobligated balances to the ITS account, and OMB must give us formal approval before we can transfer and spend any funds. Moreover, available ITS transfer funding factors into our annual budget request. During the budget process, we work with OMB to determine how much of our IT needs will be covered with funding we can transfer into the ITS account, thereby decreasing the amount of new funding we need to request in any given FY.

Most of our annual ITS funding is necessary for ongoing operational costs, such as our 800 number hardware and software and our online services. ITS transfer authority allows us to make technology improvements that help our employees work more efficiently. Our IT investments help us to achieve average annual employee productivity increases of about 4 percent in each of the last five years. They also help us maintain sufficient capacity to process and store ever-increasing amounts of data. ITS transfer authority resources helped us fund essential IT upgrade and modernization projects such as making our disability process fully electronic, developing robust and user-friendly online services, and opening our second data center. Without these IT investments we would not have kept pace with the recent increases in claims.

We did not have $600 million remaining unspent after the rescission. After the $275 million rescission, we had $276 million unspent in June 2011, of which all but $32 million was spent by the end of the fiscal year. While about $1 billion was transferred cumulatively to the ITS No-Year fund over the preceding decade (FY 2001 – 2011), we have continually spent against this funding source.

We have a number of IT initiatives critical for improving our efficiency and quality of service in progress. For example, we are:

- building a new case single processing system for State disability determination services instead of paying to maintain 54 different systems;
- building a national visitor intake system for our field offices;
- adding advanced systems capabilities in our hearing offices;
- converting our master files to DB2 databases;
- increasing the use of video for appeals and operational workloads;
- modernizing our earnings record software;
- building agile data exchange programs; and
- building additional online services that will utilize our new MySSA portal and authentication process.

11. **(From Mr. Becerra) One of the goals of the Federal Information Technology Reform Plan is to reduce reliance on agency data centers and transfer more functions to hosted servers ("the cloud"). Please describe the extent to which Social Security has moved services to the cloud, or chosen not to, and why. What are the risks and advantages for Social Security of moving to the cloud? Could Social Security generate short or long-term cost savings or performance improvements by moving some services to the cloud?**

    Please see Attachment 2, our Cloud First Plan, which contains a comprehensive explanation of our how we plan to use cloud computing.

12. **By law, if Social Security has money left in its operating budget at the end of the year, the funds are transferred to a dedicated account which is used for information technology. The Fiscal Year 2011 appropriations acts rescinded $275 million from that account. How did that rescission affect Social Security's IT modernization efforts?**

    As we mentioned earlier, we factor our ITS carryover authority into our annual budget requests. With this authority, we have been able to reduce our annual budget request and maintain robust investments in technology to improve productivity and accuracy. The rescission reduced some of our planned IT work. As explained above, we used this ITS funding source in lieu of asking for additional funding. In our FY 2013 budget request, we did not plan to have prior year carryover available; therefore, our budget request for ITS is $182 million higher than our annual ITS funding in FY 2011.

    Our systems and electronic services are some of the best in Government and the private sector and we need appropriate funding to continue to ensure the security of our sensitive information, increase online services, and pursue technology to increase productivity and improve our accuracy. Inadequate funding could result in increased traffic on our 800 number and in our field offices, creating an increased demand and additional strain on our reduced direct service staff. Continued reductions in our overall funding will severely jeopardize our service to the public and threaten our ability to keep our technology environment operating smoothly.

Attachments:
Attachment 1 – Application Information Report
Attachment 2 – Cloud First Plan

Application Information Report

Name	Owner	Description
1% Leed File Prep	OEEAS	Provide OP, Office of Research, Evaluation and Statistics with MI and data files of a 1% sample of the U.S. workforce.
40 Quarters of Coverage	OEEAS	Provide the States with quarters of coverage information per their request.
800# Appointment System	ORSIS	800# appointment system establishes leads, appointments and a protective filing date for individuals who contact SSA.
941T/DIR	OEEAS	These jobs update the IRS employer files with data received from IRS. ER941DIR updates the 3 non-current year VSAM file directly. ER941T updates the current Tax Year by downloading the file and then reproing it back up after updates have been applied.
AACT/FACT	ORSIS	Query of Master Beneficiary Record returned to the screen or sent to a printer. Queries just read the data and display the information.ORSIS does not own all queries in this Endevor System.
Access Control Utility	OSES	Access Control Utility allows users to authenticate via KBA or Pin Password
Access Control Utility Operation Handler	OTSO	This is a utitity application on OTSO's Access Control Utility (ACU) servers. This application provides an interface between the Tivoli Access Manager Product and the ACU. It can direct authentication requests to the proper modules.
Access for Cross-Platform Intranet Services	OEEAS	Access for Cross-Platform Intranet Services (AXIS) allows ColdFusion applications, hosted on the Solaris UNIX Flex environment, to access mainframe resources on z/OS. AXIS provides Top Secret security, via the Security Web Service (SWS), so that ColdFusion applications can leverage the security infrastructure that previously was only open to the WebSphere environment. AXIS uses the SSA standard jWICS to provide reliable and scalable access to mainframe resources. Any developer that knows how to use SOAP/WSDL-based web services will be able to use AXIS.
Access to Financial Institutions	OASSIS	The Access to Financial Institutions (AFI) system will help reduce SSI payment errors by providing an automated, efficient and economical means of verifying disclosed financial accounts and detecting undisclosed financial accounts with balances.
Access to Financial Institutions - Inbound Web Service	OSES	The AFI Inbound Web Service is new for AFI Release 2. The purpose of this service is to accept incoming Financial Institution "Response" data from the Vendor. This application will perform standard external facing web service security and schema validation. It will then take the message payload and place onto WebSphere MessageQueue for retrieval by the AFI application.
Accounts Receivable System	OASSIS	T16 nonreceipt

Application Information Report

Name	Owner	Description
AccuW2c	OEEAS	AccuW2C is used for electronic filing of corrected wage and tax statement (EFW2C). The software is downloaded from the SSA Web site by a submitter and used to check the format of a wage report submission file. This software is used only for testing files and does not update or modify the original file. Once errors are encountered, the original file must be accessed for corrections. The submitter should make the changes indicated on the error report generated by the AccuW2c software prior to sending the wage report submission to SSA.
AccuWage	OEEAS	AccuWage is used for Electronic Filing of Wage and Tax Statement (EFW2). The software is downloaded from the SSA Web site by a submitter and used to check the format of a wage report submission file. This software is used only for testing files and does not update or modify the original file. Once errors are encountered, the original file must be accessed for corrections. The submitter should make the changes indicated on the error report generated by the AccuWage software prior to sending the wage report submission to SSA.
Acquisition Planning and Reporting System	OEEAS	APRS maintains budget information for purchase requisitions for ITS projects
ACU Citizen PIN / Password Authentication	OSES	This is the Access Control Utility (ACU) application that performs the PIN / Password authentication for Citizen Applications. Currently supporting online applications like COA, DD, and CYB.
ACU Citizen PIN / Password Registration	OSES	This is actually a suite of applications that reside on OTSO's Access Control Utility (ACU) servers. The applications are used to register a Citizen for a PIN and Password to access online applications like Direct Deposit (DD), Check Your Benefits (CYB), and Change of Address (COA). The applications are Get Temporary Password Request Code (IPS_GPRC), Create Password (IPS_CRPW), Block Access (IPS_BKAC), and Change Password (IPS_CHPW).
ACU Core Services	OTSO	This is the shared library that provides the security logic as part of OTSO's Access Control Utility (ACU) servers. This code is used by several of the ACU applications. It provides for the actual authentication, registration, and account maintence options.
ACU Knowledge Based Authentication	OSES	This is the Access Control Utility (ACU) application that performs the Knowledge Based Authentication for online Citizen Applications. Currently supporting online applications like Citizen PIN / Password Registration, iSNO, and English / Spanish Retirement Estimator.
ACU Telephone PIN / Password Registration	OSES	This is actually a suite of applications that reside on OTSO's Access Control Utility (ACU) servers. The applications are used to register a Citizen via the Verizon 800 number for a PIN and Password to access SSA's applications like Telephone Check Your Benefits (TPCB). The applications are Get Temporary Password Request Code (TPS_GPRC), Create Password (TPS_CRPW), Block Access (TPS_BKAC), and Change Password (TPS_CHPW).

Application Information Report

Name	Owner	Description
ACU Treasury Check Information System Federation	OTSO	This is the OTSO Access Control Utility (ACU) code that provides Federated Identity services to FMS. This authenticates SSA employees to access the Treasury Check Information System (TCIS) and provides the SAML exchange with FMS for single-sign on to the system.
ACU Web Services Authentication	OTSO	This Web Service on OTSO's Access Control Utility (ACU) servers is used by the Secure Web Services Architecture (SWSA). The SWSA DataPower XML gateways leverage ACUWS to authenticate Web Services clients against SSA custom user repositories like Top Secret and IRES.
ACU Word of the Day	OTSO	The Word of the Day application was created by OTSO to add another layer of complexity for accessing SSA's Outlook Web Access (remac.ssa.gov). This application runs on OTSO's Access Control Utility (ACU) servers. It prompts a person for a Word of the Day that they must know from an intranet source.
Administrative Payments Information Network	OEEAS	This system is an intranet website that displays administrative payment information to employees
Advanced Fugitive Felon Notices	ORSIS	Produces advance notice of intent to terminate benefits to fugitive felons.
Agency Skills Inventory	OEEAS	This application provides management with a mechanism to capture individual employee skill levels for skills sets associated with job series within their organization. It also stores future needs so that gaps can be determined by comparing current skills to future needs.
Aggregate Earnings Exchange	OEEAS	Back end aggregate computation program built to provide the Department of Education (ED) with the mean and median income for each unique combination of Gainful Employment (GE) Program and Earnings Report Year. This application will provide ED with earnings data that will be used in calculating a 'Debt to Earnings' ratio as part of the Gainful Employment regulations.
AJS Notices	ORSIS	To produce a quality PE notice using Target Notice Architecture (TNA) for the AJS process.
Alpha Employer Identification File/Alpha Employer Index Query	OEEAS	AEIF - Is representative of the EIF database in alphabetic order. AEQY - The official name is the ?EIF Access Screen.
ALPHIDENT and NUMIDENT Queries	OEEAS	Provides query access to ALPHIDENT and NUMIDENT.
Annual Awards	OEEAS	This is a mainframe job that provides stats on claims awarded annually.
Annual Termination System	OEEAS	This is a mainframe job that provides stats on claims terminated annually.
API GREP Count Balancing	OSES	The application program interface that takes counts from MESODS and writes them to the MSHARE common balancing table for applications using the MESODS API.
APM Online	OESAE	This application is used to gather APM data
Appeals Management Information	OASSIS	Produces files of cases pending at OHA.
Appeals Review Processing System	ODS	Supports the case processing of appeals council workloads.
Appeals Review Processing System - Management Information	OASSIS	Appeals Review Processing System - Management Information is a system that produces web reports and listings regarding the Appeals Council, DRB and Court appeal processes.
Application Interface Facility - 800#	OESAE	AIF

Application Information Report

Name	Owner	Description
Application Interface Facility - Alphident	OESAE	Application is being moved to OESAE DDBS
Application Interface Facility - CPS	OESAE	AIF
Application Interface Facility - DCF	OESAE	this is a utility to access mbr, ssr, and rep payee information
Application Interface Facility - DMS	OESAE	this is a utility to access mbr, ssr, and rep payee information
Application Interface Facility - Earnings Modernization and Employer Balancing	OESAE	Application is being moved to OESAE DDBS
Application Interface Facility - Earnings Modernization and Employer Reporting	OESAE	Application is being moved to OESAE DDBS
Application Interface Facility - ICDB	OESAE	this is a utility to access mbr, ssr, and rep payee information
Application Interface Facility - MBR	OESAE	AIF for the MBR
Application Interface Facility - MCS PF	OESAE	this is a utility to access mbr, ssr, and rep payee information
Application Interface Facility - MEF	OESAE	Application is being moved to OESAE DDBS
Application Interface Facility - MES PF	OESAE	Application is being moved to OESAE DDBS
Application Interface Facility - MSSICS PF	OASSIS	DDBS software to access master files thru the use of user defined Data Element Clusters
Application Interface Facility - Numident	OESAE	Application is being moved to OESAE DDBS
Application Interface Facility - Rep Payee	OESAE	Application is being moved to OESAE DDBS
Application Interface Facility - SSR	OASSIS	DDBS software to access master files thru the use of user defined Data Element Clusters
Appointed Rep - Hearing Office Status Report	OSES	Appointed Representative with eFolder access will be allowed to view and download a status listing of all of their cases pending at the Hearing level. Previously ODAR would mail this information to the appointed representatives on a regular basis.
Appointed Rep Services (Form SSA-1699)	OSES	Application allows registration of Appointed Reps through intranet via input of SSA-1699.
Appointed Representative Database Query	OSES	The Appt Rep New ARDB Query project will replace the SSA-1699 and SSA-1694 query functionality that is currently available with the Appointed Representative Application on I- Main. The new Appointed Representative Database (ARDB) query application will allow users to query additional data stored on the ARDB as well as the Integrated Registration Electronic Services (IRES) database. The New ARDB Query application will include a Search for Representative Data query and a Search for Business Data query. SSA users authenticated by TopSecret will have access to the New ARDB Query Application through their customized I-Main menu page. The New ARDB Query application will provide view only capability.
Appointment System Management Information	OEEAS	Provides Management Information on the 800 appointments system and appointments scheduled via the IAppointment System.
Assignment & Correspondence Tracking	OEEAS	Intranet only Application - COTS Package heavily integrated
Attorney Fee Form 1099	ORSIS	Process registeration of individual representatives, including attorneys and eligible for direct payment non-attorneys (EDPNA). Process registration of firms. Process Linking the Appointed Rep to the Claimant.

Application Information Report

Name	Owner	Description
Attorney Fee System	ODS	Tracks fee agreements, fee petitions and miscellaneous actions primarily for cases processed by the Appeals Council. This includes both initial filings and administrative reviews.
Atty Fees Internet Registration (Form SSA-1694 for Firms)	OSES	Application allows representative firms to register with SSA for copies of the electronic 1099s that would be paid to their reps working for the firms.
Audio Cassette Transcript Invoice & Inventory System	ODS	Tracks and monitors the hearing cassette transcription process for cases being prepared for court. (used by OAO Contract Staff)
Audit Core Services	OEEAS	The Audit Core Service provides the capability to write audit records to the CATF and the Audit Trail System
Audit Trail System	OEEAS	Collect application specific transaction data and provide search capability for the Center Directors for Security and Integrity and their staffs.
AURORA	OESAE	Creating notices and modifying/completing non-complete notices; formatting and creating print files.
Automated 101	ORSIS	Collects information for Title 2 Initial Claims which cannot be automated, so that information can be transmitted and processed in the PCs.
Automated Enumeration Screening Process	OEEAS	AESP matches new applications for an original or replacement SSN against all existing SSN records. When a prior SSN is alleged, AESP will match using the alleged prior SSN and other identifying data. These match functions are performed using the NUMIDENT, which is a DB2 database. Assigns original SSN s.
Automated Job Stream - AJS 1	ORSIS	The Automated Job Streams 1 and 3 (AJS1 and AJS 3) Operations computes benefit changes based on recent AERO, Enforcement and Earnings work information. AJS 1 receives 2 types of daily inputs from POS, recomputations (BIR's) resulting from additional earnings posted to the MEF. Additionally, the AERO selection process sends transactions on the last Friday in March and October.
Automated Job Stream - AJS 3	ORSIS	The Automated Job Streams 1 and 3 (AJS1 and AJS 3) Operations computes benefit changes based on recent AERO, Enforcement and Earnings work information. AJS 3 processes transactions associated with imposing, removing, or adjusting work deductions.
Automated Leave Slip	OEEAS	MS outlook form that allows for electronic submittal and approval/denial of leave requests. Available to all SSA employees.
Automated Scheduling Application	ODS	ASA is a web application and a series of COBOL and Java batch jobs that automate the scheduling of hearings before the administrative law judges (ALJs) as part of ODAR's appeals process. ODAR has the ability to enter availabilities on behalf of representatives, medical experts, vocational experts, and hearing reporters into the ASA web application, along with the availability of the hearing sites. In ASA they also have the ability to approve proposed schedules, and to manually schedule cases. The batch portion of ASA will take the availability information and try to come up with a proposed schedule for cases from CPMS that are ready to schedule. Scheduled for pilot in August 2012.

Application Information Report

Name	Owner	Description
Automated Scheduling Application (Internet)	OSES	The Internet ASA is the user interface that allows external users to enter information about their availability to attend hearings. This information is stored by ASA databases so that it can be considered by the Intranet ASA during processing. The Internet application uses ODS created Stored Procedures to obtain data to display to the user such as their name, address, and hearings schedule.
Automated Scheduling Application MI	OASSIS	Auto Schedling Application. Primarily the OASSIS MI team will be transmitting full daily data unloads of Auto Scheduling tables (MAUSCH)and monthly unloads of a few tables to ODAR/ DART. The MAUSCH tables will not contain history and the source of the data will be the PAUSCH database. This frequency is Monday - Saturday.
Automated User Account Setup	OSES	This application provides registration and account maintenace for Electronic Records Express users.
Automatic Earnings Reappraisal Operation	ORSIS	Increase the Primary Insurance Amount (PIA) based on additional earnings. Verify PIA computation in certain entitlement conversion cases.
Automation of SSI Redetermination Change Rate	OASSIS	COBOL batch application used by OQP to determine effectiveness of SSI REDET Process
Behavioral Management Information	OSES	The Behavioral Management Information (BMI) application is used to capture information regarding user behaviors associated with the Agency's Internet applications. Information captured includes fields, pages, and applications accessed; time spent completing fields, pages,and applications; and points of abandonment.
Beneficiary Annotation Communications Operations Module	ORSIS	BACOM establishes an MBR connection between T2 and T16 and processes subsequent SSI entitlement changes. Its major function is to update the MBR or Systems Interface Records with SSI data and Railroad data. BACOM also builds death termination and death reinstatement finders for processing by T2.
Beneficiary Data Exchange	ORSIS	The BENDEX system provides Title II benefit data from the Master Beneficiary Record (MBR) and Earnings information from the Master Earnings File (MEF) to State Agencies for their use in determining the amount of public assistance for which a beneficiary is eligible.
Beneficiarys Own SSN Offline Verification Activity	ORSIS	T2 Batch BOAN Verification
Benefit Certification and Accounting System (TITLE 8/16)	OEEAS	BCAS is used to certify and account for monthly Supplemental Security Income (SSI) and World War II Veterans (T VIII) benefit payments authorized under the Social Security Act. BCAS interacts with the Treasury Dep
Benefit Rate Increase - BRI Special Update	ORSIS	Applies Cost of Living increases. The BRI does a complete replacement update of the MBR. In order to do this BRI needs a DASD allocation of about 4000000 tracks. The BRI is a called program out of the BRMBR jobs.
Benefit Rate Increase - Computations	ORSIS	Applies Cost of Living increases. The BRI does a complete replacement update of the MBR. In order to do this BRI needs a DASD allocation of about 4000000 tracks. The BRI is a called program out of the BRMBR jobs.

Application Information Report

Name	Owner	Description
Benefit Verification	OSES	Application for Title 2, Title 16 and Medicare beneficiaries to request a benefit verification letter.
BEST (MCS Screen and Print)	ORSIS	Online benefit earnings statement produced through MCS screen. NOTE: there is another system called BEST that is not part of MCS.
BSO - Direct Deposit	OSES	Allows registered banks to upload reporting files.
Business Intelligence Data Delivery Service	OEEAS	BIDDS is an application providing SUMS ODS data to regional applications.
Business Intelligence Repository	OEEAS	This is the metadata repository for the BI Architecture.
CA Role & Compliance Manager (RCM)	OESAE	CA Role & Compliance Manager (RCM) is a COTS package. CA RCM's main functional area is Identity Compliance and Role Management. Identity Compliance activities focus on verifying that the access maintained by users is in adherence with regulatory requirements and internal security policies. Role Management focuses on the complete lifecycle of building, testing, maintaining and optimizing role models.
Case Processing Management System - Management Information	OASSIS	MI for ODAR Case Tracking System changed Acronym to CPMSMI
Case Processing Management System (Front End and Back End)	ODS	Supports the case processing of hearing office workloads. WebSphere z/OS Java front-end, COBOL/DB2/CICS backend. Also includes COBOL batch (for communicating with MI, PCACS, others), and Java Batch (for implementation of Automated Noticing and CD Burning.
Catalog of Modernized Systems Operations Manual (MSOM) Procedures	OSES	The Catalog of Modernized Systems Operations Manual (MSOM) procedures known as CAMP, tracks and stores 3,300+ MS Word documents for the MSOM Staff. CAMP is essentially a system that tracks MSOM procedures (Word files), MSOM authors (Systems Analysts) and MSOM Transmittals (Projects). It is written in Microsoft Visual Basic 6.0. It houses the database of MSOM procedures, transmittals, and authors on a SQL Server 2005 database. It allows the MSOM staff to check out files to authors, associate files (procedures) with transmittals, publish transmittals as either a PROD (production) transmittal, or a DIT (future implementation transmittal), or a Supplement (pilot transmittal), and report summary information to an FTP server, where the PolicyNet Staff in ORDP collects the files, and processes them for posting on PolicyNet.
CD Encryption Script	ODS	Client-side VBScript that semi-automates the Windows encryption process when a CD is burned. Interim solution until an enterprise method is made available.
Central Image Print Architecture	OESAE	CIPA will allow us to centrally print images that are stored in DMA.
CFRMS Update Data Extract	ORSIS	CFRMS establish. maintain, and manage the retention, disposition, and disclosure of claims file records as part of the Records Management Infrastructure (RMI) and CFMS.
CICS Online Internet Support System	ORSIS	This system is the Client Password screen. It is an option off the shared process menu off the SSA Main Menu. It is used to present information to an SSA employee about a person's attempts to establish a password on the Internet to do business with SSA.

Application Information Report

Name	Owner	Description
CICS Transaction Gateway	OTSO	IBM software that provides an interface for Websphere apps to CICS backend apps.
Civil Action Tracking System	OEEAS	Tracks various court cases against SSA. This involves loading potential class members and associated information; tracking the notice dates and responses; updating addresses and decisions, issuing and tracking alerts; folder protection triggering and court case monitoring.
Claim File Record Management System	OESAE	Provides a National Archives and Records Administration (NARA) compliant architecture for managing SSA's claims file records.
Claim File User Interface	OESAE	Provides the ability to search the CFRMS database for a claims SSN or a the clients own SSN and display a view of the claims file folder and the associated artifacts in the Document Management Architecture (iDib, Paperless, Medicare Prescription Drug Subsidy) and the Online Retrival System (applications and notices) in addition to the PCACS and SSICS folder locations.
Client Host Access Tool	OASSIS	An application interface utility written in C/C++ which was designed to perform EHLLAPI functions for the CHIP application. Its use has been extended to other applications (Paperless & CDW) which also need access to mainframe resources from a client/server.
Client Server eForms	ODS	The client server version of the eForms application is a stand alone application. The forms in this version were designed using FormFlow. These electronic forms are used by the disability process.
Combined Federal Campaign	OEEAS	This system is used to monitor the Combined Federal Campaign. Employee contributions are totaled by component offices. There are several reports that provide information for the CFC project director.
Compassionate Allowance / Quick Disability Determination	OASSIS	Provides Management Information (MI) by reporting various measures on Compassionate Allowance (CAL) and Quick Disability Determination (QDD)cases via weekly, static reports
Component Mediation Manager Service	OESAE	The CMMC service is a retrieval-only service. It retrieves configuration information from the SOA DB2 database about a CMM service. The CMMC service formats the configuration information in XML format.
Comprehensive Integrity Review Process	OEEAS	Detection and deterrence of employee and client fraud.
Comprehensive Integrity Review Process Management Information	OEEAS	Provides CIRP Management Information (MI) for potential Enumeration, SSI and Title II Fraud and Misuse. MI consists of Receipts, pending and clearances sent to DCBFM and operations for investigation.
Comprehensive Work Opportunity Support System	ORSIS	This project supports the Ticket to Work program. OASSIS is updating the CWOSS MI Reports for the next release to replace the EIN with the DUNS number.
Consent Based Social Security Number Verification	OSES	A fee-based social security number verification service.

Application Information Report

Name	Owner	Description
Content Object Deletion System	OESAE	The Content Object Deletion System (CODS) is an application that is designed to provide content deletion for individual documents stored in SSA content repositories such as IBM OnDemand and IBM Content Manager for z/OS. CODS will be used for deleting claims related information from SSA repositories to comply with National Archives and Records Administration (NARA)from the DMA, ORS, and Paperless Applications.
Continuing Disability Review Operational Data Store	OASSIS	CDR ODS provides data needed to control, count and analyze all Title II, Title XVI and Title XVIII disability post-entitlement workloads.
Continuing Disability Review Workload Management Information	OASSIS	CDR WMI tracks each pending CDR on the DCF from the point that it is released to a processing component (FO, DDS, DQB or PSC) through the final completion of all DCF processing events, including some appeals.
Continuous Work History Sample	OEEAS	This system creates files containing earnings, coverage, benefit and demographic data for 1% of SSN holders. The data is used by OCACT in making fiscal projections and by ORES in providing statistical information to other government entities and the public.
Continuous Work History Sample Modernization	OEEAS	Modernization of legacy CWHS system. Uses DB2 database that replaces flat files.
Control & Tracking API	OSES	The Control & Tracking API is a common component used by OSES Internet applications to generate control numbers that are associated to web application submissions.
Control & Tracking Web Service	OSES	The Control & Tracking Web Service is a redesign of the Control & Tracking API. This new service is used by OSES Internet applications and generates control numbers to associate to submissions. This service tracks submission level records only.
Cost Analysis System	OEEAS	This is the Cost Analysis System for the Agency. This is a mainframe based application that provides MI on administrative costs associated with the various SSA programs. CAS provides unit cost data for the various SSA workloads.
Cost Analysis System Renovation	OEEAS	This is a mainframe application that provides workload count data, work year data and work sample tallies to the Feeder CAS system from various source systems (WMT, PCMI, OEO, etc.).
Cost Analysis System Replacement	OEEAS	This is a intranet application that is a technical replacement of the current Feeder CAS system.
Critical Payment System	ORSIS	Immediate, one time and cyclical payments to people who will be in pay on the MBR in the future but who are not currently being paid.
Cross Payment Recovery	OASSIS	This application makes collections on behalf of T2. When a T16 underpayment is recognized, a call to T2 is made to reconcile a T2 overpayment.
CSIVEN	OESAE	Application programs that run on production for criterion-based selection.
CSMISC	ORSIS	CSMISC is a miscellaneous operation that creates post files for CSPOTRUN; files for the L9790 mailer; files for CSMBRSEL-arf drc and spa life.

Application Information Report

Name	Owner	Description
CSRETAP	ORSIS	CSRETAP identifies cases for post entitlement processing and information exchange. It also produces beneficiary counts, maturation events, finders for age attainments, full and partial MBR records and maintenance and update transactions.
Customer Help and Information Program	OASSIS	An intranet application which is used by the 800#agents to assist in answering phone inquiries. This intranet application also retrieves data from certain mainframe records along with performing screen stuffing of data to certain mainframe screens.
Customer Service Record Management Information	OEEAS	standard management information reports from the Work Measurement Data Warehouse (WMDW) on Field Office visits and Field Office waiting time. The information used to create these reports will be provided by the Visitor Intake Process (VIP) and the Customer Help Information Program (CHIP) (VIP).
Customer Service Record System	ORSIS	Collects pertinent customer information that provides a view of recent transactions, outstanding work items, and future actions for the field offices. The CSR query retrieves data from 16 systems.
Customer Status Inquiry	OSES	Customer Status Inquiry (CSI) is an application used by OSES internet applications to view details of and track the status of submission records created in the Control and Tracking (C&T) and/or Secure Messaging systems.
Daily / Yearly PHUS Update Operation	ORSIS	Payment History Update System is a database that houses all T2 payments made to T2 beneficiaries since 01/01/1984. The purpose of this database is to assist with generating form SSA-1099 or SSA-1042 SS Benefit Statements in support of P.L. 98-21 which made Social Security benefits taxable for individuals with certain income thresholds.
Daily Financial Accounting System	OASSIS	Creates a file of all SSI accounting transactions as well as various accounting reports detailing these totals.
Daily NUMIDENT Update	OEEAS	Updates the NUMIDENT master files.
Daily Update Data Exchange	ORSIS	IEDUDEX compares the old and new Master Beneficiary Records (MBR) after the daily update. The system identifies changes in MBR data or status, creates a series of files that reflect the changes and send the files to various agency components and other federal agencies. Those include SSI, Office of the Actuary, VA, CMS, and IRS.
Daily Update MASTER Accounting System	ORSIS	This operation checks and validates initial claims and PE events and prepares a record to update the MBR.
Data Access Middleware Utility	OESAE	Provides non mainframe access to SSA's mainframe Master Files.
Data Entry Mask System	ORSIS	Administrative Applications, Delayed Queries, Data Inputs
Data Exchange Management Information System	OEEAS	A repository for Data Exchange Information.
Data Exchange Query Menu	OEEAS	Process queries for online data exchanges.

Application Information Report

Name	Owner	Description
Data Exchanges and Verifications Online	OEEAS	DEVO is a parameter-driven, back-end engine for processing SSN verification requests. It replaces the exisitng Enumeration Verification System (EVS). DEVO is a WebSphere/JAVA application, modeled after the DCS Framework. DEVO interefaces with the Verification Account Management System (VAMS) to manage the assignment of functional processes. DEVO is the foundation for improvements to both batch and real time verification and data exchanges.
Death Alert, Control and Update System	OEEAS	The system processes reports of death and sends alerts to the field and death data to the NUMIDENT file.
Death Extract for DACUS	OASSIS	Process DACUS Death Extract - This program was written to process incoming V42 records from the ZDFAN Operation and format them into extract records to be used as finders for input into the State Death System.
Death Match to Payment Master	OEEAS	The system matches death records on the NUMIDENT file to death data on the MBR and SSR.
Debt Management System	ORSIS	Any system that includes the Debt Management screens, the conversion process that creates transactions, file maintenance for several debt management files, and the remittance batch process.
Detailed Office Organization Resource System	OEEAS	The Detailed Office/Organization Resource System (DOORS) is SSA s official Agency repository of office information, such as location and phone numbers, for all SSA offices. DOORS has a user and customer base of all SSA employees, hundreds of SSA systems, and members of the public who use SSA.GOV on the Internet.
Digital Recording	ODS	This project provides equipment and software to support the recording of hearings in ODAR.
Disability Adjudication and Review Evaluation System	OEEAS	DARES is a ColdFusion application that provides MI on the various initiatives that are under way to reduce the hearings backlog. It accesses an Oracle database in the UNIX Sun Solaris environment. DARES links to the Quality Performance Management System.
Disability Case Adjudication and Review System	OASSIS	Client-server application used by the Disability Quality Branches to manage the quality assurance reviews of DDS determinations. Works in conjunction with the Disability Quality Review (DQR) application which will eventually replace it. Data is exchagned with the Electronic Folder Interface (EFI) application using our Quality Assurance Systems Message Router (QASMR) application/service.
Disability Case Processing System	ODS	Disability Case Processing System. Used by disability determination components to process disability claims.
Disability Control File	ORSIS	This application group supports the batch interfaces between multiple SSA systems and the DCF and the updates from the IDMS CICS screens to the DCF in support of CDRs, Earnings, Demo and ticket to work activities.

Application Information Report

Name	Owner	Description
Disability Database System	OASSIS	DDBS extracts initial disability claims and continuing disability review cases daily from NDDSS and weekly determinations processed by OHA, OD, and other components from forms SSA-831/833/892/899 keyed by the Wilkes-Barre Operations Center. This data in saved in weekly files created for the Office of Disability and for the Integrated Work Management System (IWMS). Used for District Office Workload (DOWR) Counts. The DOWR counts are how much employees produce. DOWR measures the number of various types of actions that are completed. DOWR counts are derived from input to the system. Volume counts of specific workloads cleared.
Disability Online - Electronic Disability Guide	ORDP	
Disability Operational Data Store	OASSIS	DIODS provides disability management information for regional office Disability and MI staffs, Central Office Disability and Budget staffs, and state DDSs. The purpose of the Disability Operational Data Store (DIODS) is to provide a single source of disability management information (MI). To this end, a DB2 relational database will house disability data organized in detail and summary level tables. Produces SAOR and FD:15 reports.
Disability Predictive Model	ODS	Dual score Quick Disability Determination (QDD)application written by IBM. This application will replace the original, single score, QDD application. Called when initial adjudicative disability cases are transferred to the DDS for a medical determination, the new application will produce two values, each between 0 and 1. The first value will express the confidence that a favorable determination will be made (known as SSAL - SSA Allowance). The second (known as SSPT - SSA Processing Time) will express the confidence that the determination can be reached quickly.
Disability Quality Review	OASSIS	DQR is a JAVA web based application that will replace the legacy Disability Case Adjudication and Review System (DICARS) application. The purpose of DICARS/DQR is to provide a system for performing in-line quality reviews of cases/claims adjucated by the Disability Determination Services. Data is exchanged with the electronic folder (EFI) application using our Quality Assurance Systems Message Router (QASMR) application/service.
Disability Railroad Alien Military Service Operation	ORSIS	Disability, Railroad, Alien, Military Service Operation (DRAMS) is a repository for certain information collected and used during the claims taking process. The repository was developed to serve multiple purposes. The initial Title II Claims Process electronically accesses the DRAMS file to ensure that payments are properly made, taking into consideration whether the individual is entitled to a RR annuity, whether the military service was properly credited, and whether the claimant has been deported.

Application Information Report

Name	Owner	Description
Display Records In Paperless Tracking	ORSIS	This system tracks the T2 actionable output results in electronic document form from PCACS to PSC Local Programming and back. The system identifies any missing or invalid documents by file per rundate. Once all actions are accounted for, the output is sent to the Paperless system.
District Office Workload Report	OEEAS	This is an MI report that provides data on field office workloads. It is a subsystem of IWMS and has been replaced by the WMT/DOWR standard report that is available via MI Central.
Document Conversion Engine	OESAE	An Enterprise Conversion Engine using Web Services/API as an interface for applications.
Document Generation System (Front End and Back End)	ODS	This project supports the creation of forms and notices for ODAR operational components at the Hearings Level, Appeals Council, Court, Medicare Part-D, and Congressional Interest (CPAB). DGS is a client server application: Visual Basic for Applications (VBA) in MS Word frontend and a CICS/DB2 backend.
Document Management Architecture-eClient	OESAE	DMA API's and Viewer code
Document Processing System	OESAE	Web based manual notice system for FOs.
DOL Black Lung Part C	ORSIS	To match SSA cans vs. DOL SSN's and prevent overpayments on both systems.
Drawing Information Management System	OEEAS	DIMS Phase One is a repository for agencys' AutoCAD drawings. DIMS Phase Two is a GIS enterprise solution to be used for analyzing, planning and decision-making for security and emergency management.
Dual Entitlement Maintenance System	ORSIS	Dual Entitlement Maintenance System - the purpose of DEMS is to ensure that the Master Beneficiary Records for dually- entitled beneficiaries are properly updated on a post- entitlement basis or as a result of an initial award processed via MADCAP with proper DE Data coded. Prior to the 05/2008 release DEMS was fed records based on an MBR updated by T2. Since the 05/2008 release only MBRs updated by MADCAP feed the DEMS process.
Earnings Alerts	OEEAS	The Earnings Alert System (EAS) is a stand-alone system which identifies specific posting irregularities with an individual's Social Security earnings record.
Earnings and Enumeration Report Access System	OEEAS	The VSAM database for this system is the repository for various MI earnings reports in OEEAS/DECU/EUEB. EERAS has screens for accessing these reports. This system provides a paperless mechanism for delivering reports to MI customers.
Earnings Batch Accounting System Management Information	OEEAS	The MI EPOXY weekly (CBMEPOXY) job provides a report which is emailed automatically to the EPOXY MI Customers. Data is retrieved from the big EPOXY report for the Annual Wage Reporting, It's purpose is to determine that the current cycle is always checked.
Earnings Case Management System	OEEAS	This is a case management system which will track many different earnings workloads.
Earnings Case Management System MI	OEEAS	This is a system which will track many different management information metrics for the earnings workloads in ECMS.

Application Information Report

Name	Owner	Description
Earnings Coverage System	OEEAS	Provide earnings/quarters of coverage for each SSN request received from agency/company. The Earnings Coverage System provides individual earnings and coverage to requestors. Earnings Coverage neither maintains nor updates files/databases.
Earnings Data Warehouse	OEEAS	Extracts data from EMODS and updates Oracle EDW. Data used to create Management Information reports for AWR Submissions and related Earnings data.
Earnings Enforcement Operation	ORSIS	Run three (3) times a year to detect Over/Under Payments
Earnings Menu System	OEEAS	EESM - Earnings Systems Main Menu
Earnings MI Operational Data Store	OEEAS	Stores Annual Wage Reporting (AWR) data for submission level and employer level into a DB2 operational data store. Generate approx. 93 Management Information reports through ColdFusion on the EMIS website.
Earnings Modernization Itemized Statement of Earnings Reports	OEEAS	Receive requests for detailed Earnings for individuals (or reps) for various timeframes; format them appropriately and edit for accuracy before sending requests to the MEF (DB2) for retrieval or to ECMS/MOS to get the earnings posted before retrieval. Provide report to original requesting source.
Earnings Modernization Itemized Statement of Earnings Reports - MI	OEEAS	The MI system provides user reports reflecting processing counts for the Itemized Statement (Form 1826) request system. The reports reflect case totals, money amounts, years requested, third party requests, workload functions and other useful information.
Earnings Posting Overall Cross-Total Year-to- Date	OEEAS	Captures and Cross totals statistical information regarding the data flow through the weekly and daily earnings update process.
Earnings Suspense System	OEEAS	Add/Delete records to/from the suspense DB2 tables.
Earnings Use - DEQY	OEEAS	The DEQY system is the Detailed Earnings Query System, used to query the details on the Master Earnings File.
Earnings Use - SEQY	OEEAS	The SEQY system is the Summary Earnings Query System, use to query the summary amounts on the Master Earnings File.
Editor Batch	ORSIS	Title II Editor/Batch Transaction Handler processes all batch transactions that come into the T2 System. Editor BTH software performs surface edits to ensure that the data on the finder is valid, gets the MBR for processing against and performs MBR relational edits as well.
EEO Case Management System	OEEAS	Equal Employment Opportunity case tracking system
EF101	ORSIS	Collects infomration for Title 2 Initial Awards, subsequent awards or amended awards, which cannot be input through any automated system. That information is available to MACADE to be processed in the PCs.
eForms (Form Selection)	ODS	The first Web version of the eForms application has been integrated with various disability systems including, EDCS, Levy, Versa, and DICARS. The forms in this version are created in Adobe Form Designer 5.0.
Electronic Access	OSES	ID Proofing and Authentication system for SSA online applications
Electronic Authorization (Web Service)	ODS	Electronic Authorization project involves the elimination of a wet signature on the SSA-827 and replacing it with an electronic signature on an electronic form.

Application Information Report

Name	Owner	Description
Electronic Bench Book	ODS	This will be a web-based application used by decision makers (Administrative Law Judges and Senior Attorney adjudicators) in the Hearing offices to aid in documenting, analyzing, and adjudicating the disability case in accordance with SSA regulations. It will improve accuracy and consistency of the disability decision process, and it should make the decision maker s review of the efile and instructions to the writers more complete and efficient, which should provide significant time savings for ODAR and reduce the number of remands based on incomplete documentation. Decision makers will use eBB to input hearing case notes, analysis, adjudicative data, and instructions for the Decision Writers. Information entered will be saved as data and will be viewable by ODAR. Decisional notices will be generated based on data in eBB, CPMS and SDR.
Electronic Claims Analysis Tool	ODS	Web based application that guides Disablity Examiners and Medical Consultants through the sequential evaluation.
Electronic Claims Analysis Tool MI	OASSIS	The Electronic Claims Analysis Tool(eCAT) is used to document case development and the Disability Determination Services (DDS) analysis of a disability claim through the entire sequential evaluation process, including the analysis of the examiner, the medical consultant, and the vocational specialist. eCAT MI will be created to monitor and track the progress and usage of eCAT.
Electronic Disability - Management Information	OASSIS	Provides management information on the disability program. Encompasses these applications: CAL/QDD (Compassionate Allowance / Quick Disability determination) - Provides MI to stakeholders on a weekly, monthly and fiscal year in order to assess the effectiveness of the CAL and QDD intiatives. eCAT MI (Electronic Case Analysis Tool-Management Information)
Electronic Disability Collection System (Front End and CICS Mainframe Interface)	ODS	The Electronic Disability Collect System (EDCS) is the gateway to the Electronic Folder (EF). EDCS permits access to electronic versions of the many core disability forms. The EF begins with the FOs as they collect all disability and medical source information.
Electronic Folder Interface (Java and CICS)	ODS	This project checks sampling data from NDDSS (DX54) and allows components on different platforms to interface with the Electronic Folder.
Electronic Freedom of Information Act Internet	OSES	The eFOIA application provides an automated means for the Office of Public Disclosure in the Office of the General Counsel and Division of Earnings Operations in the Office of Earnings Operations to process and track Freedom of Information Act requests. The eFOIA Internet application allows for members of the public to submit their request online and have those requests submitted to the eFOIA Intranet application for processing.

Application Information Report

Name	Owner	Description
Electronic Freedom of Information Act System	OESAE	The eFOIA application provides an automated means for the OPD (Office of Privacy and Disclosure in the Office of the General Counsel) and DERO (Division of Earnings Operations in the Office of Earnings Operations) to process and track requests from the public that are governed by the Freedom of Information Act and the Privacy Act.
Electronic General Auditable Documents Store	OESAE	Centralized Storage facility for approved versions of auditable lifecycle\documents (except MSP) Maintained by OESAE/DPEPCS/PCCRB & DVTT Policy & Lifecycle integration by OESAE/DPEPCS/SPI VISOR coordination by OESAE/DPEPCS/PCCRB
Electronic Interim Assistance Reimbursement	OASSIS	Allows Regional Office users to view, change, and add Interim Assistance (IA) agencies to the eIAR database and the SSR.
Electronic Management of Assignments and Correspondence	OEEAS	Multi-purpose system to track correspondence received by OPI, and in the future it may handle controls and assignments for the agency.
Electronic Medical Evidence Print Utility	ODS	This is being transitioned to DSCS/DNSO, OTSO
Electronic Personal Enrollment Credential System	OEEAS	Replacement for the existing Workflow 1/ CERMS HSPD-12 credential enrollment application.
Electronic Quality Assurance	OASSIS	Provides quality assurance study definition, sampling, form creation, reviews, reporting, and business process management for QA reviews conducted by OQP.
Electronic Records Express Volume Reports	OASSIS	The Electronic Records Express (ERE) is an initiative by Social Security Administration (SSA), Disability Determination Services (DDS), and Office of Disability Adjudication and Review (ODAR) to offer electronic options for submitting medical evidence for disability claims. The ERE MI Volume Reporting System collects data and statistics on the items processed at the ERE website and at each Front End Capture System (FECS) servers deployed in either DDS or ODAR site.
Electronic Records Express Web Services	OSES	ERE Web Services is a secure electronic service delivery channel provided by SSA to facilitate high volume submissions of electronic evidence.
Electronic Records Express Web Site	OSES	The Electronic Records Express Web site allows evidence to be collected electronically and prepared for transmission to the electronic Disability (eDib) system. Medical providers, advocates, schools, and other sources have the ability to submit evidence needed for the Disability Determination Services (DDS) and the Office of Disability Adjudication and Review (ODAR) to adjudicate claims and conduct hearings in an efficient and expeditious fashion. The website also allows Appointed Reps to view and download the documents in their claimant's electronic disability folders (eFolders)
electronic Representative Payee System	OASSIS	This is the future system for tracking representative payee applications, notices to payees, changes to payee information, and payee misuse information. The first module released is Representative Payee Misuse, which tracks the progress of misuse allegations.
Electronic Verification of Vital Events	OSES	EVVE is an automated data exchange between SSA and a state vital statistics agency for the purpose of providing authorized SSA employees access to state vital records data.

Application Information Report

Name	Owner	Description
Electronic Work Reporting System	ODS	This application collects work reports for disabled recipients for the purpose of documenting and processing return to work actions. This began as a collaboration effort with OAS, however, effective with the beginning of FY09 it became a Systems project.
Email Core Services	OEEAS	The Email Core Service validates SSA email addresses
Employee Coding Files	OEEAS	Provides EINs NAICS codes and employer information.
Employee Express System	DCHR	
Employee Suggestion Program	OEEAS	System that Receives and Processes Employee Suggestions; Intranet Server is located in NCC - SUN SOLARIS - Suggestions are stored in Oracle database
Employer Balancing	OEEAS	Employer balancing processes employer wage reports.
Employer Control	OEEAS	Process W3 level earnings using the EIN as the key. Houses a history file that is used for the Earnings Report Query (ERQY). Refers to a number of jobs that update the employer databases on a daily basis with data received from AWR and various correction systems.
Employer Customer Help and Information Program	OASSIS	The Employer Customer Help and Information Program (ER- CHIP) is a software application that assists the Division of Business Services (DBS) Employer Reporting Technicians (ERTs) with responding to telephone inquiries from the nation's employers and/or their representatives. The intranet-based decision support application provides fingertip access to Social Security Administration (SSA) records, facts, policies, procedures, and reference.
Employer Information File	OEEAS	The database houses employer names and addresses listed by EIN.
Employer Report Query	OEEAS	Allows access to the ERVIEW and ERHF databases both in batch and online.
Employer Report Reconciliation	OEEAS	RECON is the system that compares FICA wages, Tips, and Medicare money processed by SSA's Annual Wage Reporting (AWR) system against money processed by IRS
Employer Report Reconciliation MI	OEEAS	RECON MI produces 27 reports that capture cumulative monetary data when comparing total wages between SSA and IRS.
Employer Report Trust Fund	OEEAS	This job is run quarterly and combines employer reports sent weekly and quarterly from IRS. This combined file is used by the ER941T and ER941DIR and two RECON jobs (RNSUMR30 and RNSUMR40).
Employer Reports View to Employer Report History File Download	OEEAS	IDMS database of Employer Reports for the most recent 4 years. An annual run to migrate off a year onto the ERHF, the Employer Report History File, a DB2 database of all earlier years.
Employer Retirement Income Security Act	OEEAS	The purpose of ERISA system is to produce a notice which informs retirees of their possible eligibility for pensions under a private pension plan.
EMR-Code Scanning	OESAE	Scan application code as it is released and load metadata about the code such as database access, calls, file usage into the Enterprise Metadata Repository.

Application Information Report

Name	Owner	Description
EMR-Framework	OESAE	The Enterprise Metadata Repository Framework provides infrastructure for retrieving data to load and controlling the load process. The processes to read systems such as Oracle catalogs will be scheduled and run based on a control database. The data will then be returned and the framework will control the loading of the metadata into the EMR.
EMR-UI/API	OESAE	The Enterprise Metadata Repository stores metadata about the enterprises applications and databases. The metadata repository provides logical and physical information about SSA databases. It also provides information about applications. The information includes program call, database access, copybooks and metric for complexity and maintainability. The UI provides a websphere user interface to allow users to interact and retrieve data from the repository. The API will allow applications to retrieve data from the repository.
End Of Month	ORSIS	The CSEOM/CSENDOP Claims Systems End of Month Operation provides Supplementary 1A Tables to the office of the Actuary with tables of actuarial and statistical data for preparation of the annual report to Congress.
Enforcement - SSI Earnings, IRS & OCSE Enforce	OASSIS	Reformat earnings data from the Master Earnings File (MEF) into SSI PE transactions. It processes transactions that were formatted in the SSI/IRS Interface subsystem and OCSE wage/unemployment transactions that were formatted in the OCSE wage/unemployment. Office of Child Support and Enforcement Quarterly Wages and Unemployment Data Interface. This match (Wage Match (IC/WM)) occurs six times a year (January, March, May, June, Sept and Dec. During these months OCSE wage, unemployment, IRS 1099, IRS Pension, and MEF data are processed. Once this data is processed, diaries are posted to the SSR. They are as follows: IRS PENSION (5H) MEF (K6 AND K7) OCSE WAGE (S2) OCSE UNEMPLOYMENT (U5) IRS 1099 (5B POSTED IN REDETERMINATION RUN)
Enrollment (HI and SMI)	ORSIS	A premium is due for each month of SMI coverage. The premium payable is increased if the individual enrolls late. The HI premium is based on the estimated costs that apply to beneficiaries age 65 or over during the calendar year for which the premium is effective.
Entitlement Eligibility	ORSIS	The EE function evaluated beneficiary data to determine benefit entitlement status and identify benefit conversion conditions. EE processing is month by month, BIC by BIC, function by function and is entirely data driven.
Enumeration System	OEEAS	The system collects SSN application data.
Enumeration Verification System	OEEAS	The system determines if names and Social Security Numbers received on the input match the information on SSA files, usually the NUMIDENT and/or ALPHIDENT files.
Epidemiology Research Study System	ORSIS	The Epidemiology research study system provides epidemilogical researchers with information as to whether study subjects are alive or deceased.

Application Information Report

Name	Owner	Description
ERE Login Application	OTSO	This application authenticates Electronic Records Express users with their IRES PINs and Passwords. The application is part of OTSO's Access Control Utility (ACU) servers.
eTravel	OEEAS	Enter travel documents - authorization, local vouchers and vouchers. Sign and approve documents electronically. Create transactions for the Financial Accounting System (FACTS) to obligate funds and reimburse the traveler for travel expenses.
E-Verify	OEEAS	Used by DHS for Employment Eligibility
eVerify Web Service	OSES	The E-Verify application is an Internet-based system that assists employers in verifying the identity and employment eligibility of newly hired employees. E-Verify is operated and maintained by both the Department of Homeland Security (DHS) and SSA
eView	ODS	This application displays information from EDCS and is the viewer of the Electronic Folder.
EWD TSRP soft phone	OTSO	An AT telephony device allowing interface with workstation AT devices that are integrated within the Field Office telephony services.
EWD Uniphi	OTSO	
EWR - Acknowledge Resubmission Notice	OSES	This EWR suite application allows those submitters or employers who have received resubmission notices to come into BSO/EWR to acknowledge of those notices.
EWR - Contact SSA	OSES	This EWR suite application allows PIN and PW holders who are users of BSO to send an email to their regional ESLOs with questions or concerns.
EWR - Employer Error Information	OSES	This EWR suite application allows PIN and PW holders registered through IRES to come to the BSO and check the status of their wage report submissions and to specifically view the errors affecting names and SSNs for their employees.
EWR - Employer Report Status	OSES	This EWR suite application allows PIN and PW holders who are employers registered through IRES to come to the BSO and check the status of their wage report submissions.
EWR - Intranet to Internet (I2I)	OSES	Application for internal customer service users to allow them to assist callers by seeing the submission status of what callers have submitted, along with additional information visible only to the SSA employee.
EWR - Request Resubmission Extension	OSES	This EWR suite application allows those submitters or employers who have received resubmission notices to come into BSO/EWR to request a 15 day one-time extension of the deadline that SSA has assigned to the resubmission request for the users to resend the file.
EWR - Resubmission Notices	OSES	This EWR suite application allows registered users with PIN and PW to view facsimiles of apper and eResubmission notices that they may have received on paper or electronically.
EWR - Submission Error Information	OSES	This EWR suite application allows PIN and PW holders registered through IRES to come to the BSO and check the status of their wage report submissions and to specifically view the errors that have been found in their wage report submitted.

Application Information Report

Name	Owner	Description
EWR - Submission Status	OSES	This EWR suite application allows PIN and PW holders registered through IRES to come to the BSO and check the status of their wage report submissions.
EWR - W2 Online	OSES	This EWR suite application allows small employers and charitable organizations to create Form W2s for their employees or volunteers, to submit the W2s to SSA, to keep an electronic copy for their records and print off paper copies.
EWR - Wage File Upload	OSES	This EWR suite application allows submitters and employers to upload any size of wage report file with multiple Form W2s included, or to upload wage reports for multiple employers to SSA.
EWR - Wage Reporting Web Service	OSES	Wage reporting web service that allows consolidator companies to programmatically submit wage files for their end user customers without any manual intervention. Part of the EWR suite of services.
EWR Home Page	OSES	This EWR suite application allows the user to choose the specific application to work with after choosing the option to file wages from the last IRES screen before entering the EWR suite of services.
EWR- W-2C Online	OSES	This EWR suite application allows employers or submitters to correct wage reports that they have already uploaded to SSA via BSO/EWR via a Form W2c.
Executive and Management Information System (EMIS)	OEEAS	This is an Intranet application that provides access to MI from many different sources.
External Collection Operation	ORSIS	Collects delinquent Title II and Title XVI overpayments using various debt collection tools. Tools used are: referral to Treasury for offset of federal tax refunds, administrative payments, and federal salary payments; report delinquent debt to Credit Bureaus
FALCON	ORSIS	FALCON consists of mainframe batch data entry regions for the 6 PSCs and ODIO and end of day batch processes to output the data for processing.
Fast Track Disability Processing Time Reports	OEEAS	The goals of this release are: ? Extracting the required data from the Title II ODS DB2 database. ? Extracting the required data from the Title XVI IC ODS DB2 database. ? Storing the extracted data in the WMDW Oracle database. ? Providing access to standa
FDOPS/AJS1	ORSIS	Folder Documentation Sys / AJS1 AERO
Federal Assistance Award Data System	OEEAS	FAADS is a central source of information on domestic financial assistance programs for the Federal Government. This project is administered by OMB and mandated by the Federal Funding Accountability and Transparency Act.
Federal Parent Locator System	OEEAS	The system processes alleged SSN data of absent parents, verifies if SSN is correct and indicates when insufficient data has been supplied for verification or if more review of the data sent is required.
FERRET System	OEEAS	Reinstate unposted earnings based on the IRS Individual Master File.
Field Office Locator	OSES	Allows the public to locate the servicing field office that is closest to their zip code.
Financial Interactive Voice Response System	OTSO	Allows employees to retrieve status of expense vouchers
Foreign Operations	ORSIS	Various foreign counts from the MBR

Application Information Report

Name	Owner	Description
Fraud Operational Data Store	OEEAS	Provides fugitive felon management information for field office receipts, pending and clearances. Also provides MI on fugitive felon submissions.
Front End Capture System	OESAE	Scan/Capture system for DMA
FRUIT	ORSIS	Also known as Miscellaneous Reference System which consists of PSLB9ST, PSLIMIT, PSPRUNES provide MBR data to various users upon request. These requests originate in various OAS components, PC, FO and other systems. It processes exception data from other PE subsystems converting this information to human readable formats (LIMITS) and distributes the data to the appropriate office for correction.
Fugitive Felon	ORSIS	Data Base which collects Fugitive Felon warrant data
Fugitive Reporting and Agreement Tracking System	OEEAS	The system is a repository for: Warrant issuing agencies' reporting agents' names, addresses, phone and contact information.
Full Retirement Age Computational Service	OESAE	The FRA service is a computational-only service. The service computes the full retirement age (FRA) in months, the date of FRA, and if FRA has been attained. It does not require a database connection. The service does call the global- reference-table core service to retrieve the full-retirement-age table values.
Garnishment	ORSIS	CICS data collection for Court Ordered Garnishment data. Sends transactions to Title 2 for processing. Records Title 2 results on DB and pays withheld money to the states. Also receives file from Child Support containing electronic withholding orders.
Garnishment Notices	ORSIS	Produces notices for Garnishment System actions.
General Average Current Earnings	ORSIS	This function computes the Average Current Earnings (ACE) for use in computing Worker s Compensation / Public Disability Benefit offset. It will compute the High 1, High 5, and AMW ACEs, and will determine which is the highest.
General Business Function Utilities Wizard	ORSIS	Allows invoking programs to execute some Common Title II Business Function Utilities (GUEST, GINSU, GRUMPI, GRACE, and GRATES).
General Insured Status Utility	ORSIS	Business Function utility that determines insured status.
General Rates Utility	ORSIS	RATES (A600BV09/A600CV09) performs the following computations for each entitled or recently terminated beneficiary when they apply: Computes the original benefits (OBs), and adjusts the OB for the family maximum (FMAX) Determines the original reduction factor (ORF) and reduces the benefit for age to get the monthly benefit amount (MBA) Increases the MBA for delayed retirement credits (DRCs) and adjustments of the reduction factor (ARFs) Calculates primary, spouse, and child benefits for retirement, survivor and disability claims Calculates benefits for widows, mothers/ fathers, parents, disabled widows benefits (DWB), disabled adult children (DAC's), and the minimum sole survivor rate (MSSR) determination Adjusts benefits for entitlement on more than one SSN (dual entitlement (DE)/multiple entitlement (ME)) Applies deductions for workers' compensation/public disability benefits (WC/PDB), government pension offset (GPO), and earnings under the Annual Earnings Test (AET).

Application Information Report

Name	Owner	Description
General Utility Earnings Summarization Tool	OEEAS	The General Utility Earnings Summarization Tool (GUEST) is provided to enable online and batch COBOL and ALC programs to input a number holder s identifying information and receive precise earnings and coverage data for entitlement and computation purposes. This utility extracts data from the following sources: Master Earnings File (MEF) Multiple SSN Cross-reference Database (MULTX) Disability, Railroad, Alien, and Military Service (DRAMS) File Number Holder s Identification (NUMIDENT) File Additional earnings information can be supplied by the requestor and included by GUEST. These are military service periods (for earnings credits), Japanese internment periods, and lag earnings.
General Utility Extraction of Earnings Details Operations	OEEAS	GUEEDO is a stand alone utility that reads posted and/or unposted details from the MEF record. It has a routine that will remove offset details from the record returned to the user. The user can request to have the details displayed with offsets included.
General Utility Reduced for Age	ORSIS	The Reduced For Age Utility calculates the reduced monthly benefit amount for the entitled number holder (NH). If a PIA has been calculated and the number holder is entitled, then the PIA is reduced by the original reduction factor in this function. If the NH does not have any reduction months (entitled at full retirement age or later) zeroes will be returned as original reduction factor and the PIA will be returned as the reduced monthly benefit amount. This function is invoked when the case stops processing before the completion of rates to provide the reduced monthly benefit amount.
Generation of SSI Reports to the Regional Offices	OASSIS	This process provides formatted listings of reports for various listings for the regional offices
Global Reference Table Portal	OESAE	Application used to collect data to update the Global Reference Tables.
Global Reference Table Service	OESAE	The GRT service is a process that provides data access to the DB2 Global Reference Tables. It incorporates the business logic that is needed to access the tables correctly.
Global Reference Tables Core Service	OEEAS	Core Service Returns Global Reference Tables
Government Information Exchange website	OSES	The Government Information Exchange website is a project managed by the Office of Systems Electronic Services Division of Non-Benefit Software Development (OSES/DNSD). This website provides a centralized location to obtain information on various data exchanges.
Government to Government Services Online Registration	OSES	This application provides registration and account maintenace for GSO users.
GSO - Birth Reporting	OSES	Allows registered users to upload birth reporting files and download results files.
GSO - Black Lung Reporting	OSES	Allows staff at the Department of Labor to upload files containing data about Black Lung beneficiaries.
GSO - Data Exchange	OSES	Allows registered users to transfer data files to one another in a secure manner.
GSO - Death Reporting	OSES	Allows registered users to upload death reporting files and download results files.

Application Information Report

Name	Owner	Description
GSO - FRATS	OSES	Allows an individual in OIG to upload the FBI's law enforcement agency address file to the Fugitive Reporting Agreement Tracking System.
GSO - Fugitive Felon Reporting	OSES	Allows registered users to upload fugitive felon reporting reporting files.
GSO - Interim Assistance Reimbursement	OSES	Allows registered users of Interim Assistance (IA) agencies to query SSR data on individuals requesting SSI and receiving state assistance. Once an individual is determined to be eligible for SSI, registered users of IA agencies submit data on assistance given to an individual. This information is used by SSA to determine the amount of assistance that is reimbursed to the IA agencies.
GSO - OCSE Applications	OSES	Allows registered users to Office of Child Support Enforcement (OCSE) reporting reporting files. Files are transferred to OCSE mainframe, not to any SSA application.
GSO - Pension Benefits	OSES	Allows registered users at the Pension Benefits Guaranty Corp to upload pension benefit reporting reporting files.
GSO - Prison Reporting	OSES	Allows registered users to prison reporting reporting files.
GSO - Secure Messaging	OSES	Allows registered users to securely send messages and attachments to other registered users. Requires a relationship to first be established between sender and recipient in the GSO Registration Application.
GSO - Sheltered Workshop	OSES	Allows registered users to send one file of Sheltered Workshop wages to designated recipients.
GSO Death Data Exchange	OSES	The application allows Totalization partners to upload information about SSA beneficiaries who have died in their country, for SSA's use in terminating benefits, or information about their beneficiaries they believe reside in the US.
GU80C00 - Utility	ODS	Works with WICS on the mainframe CICS side. Accepts client-side requests and routes them to the correct CICS module, and collects the response from the module
GUMFCONF - Utility	OSES	This is the application configuration file used by GUMFWEB.
GUMFWBT - Utility	OSES	encapsulates the GU80C00 boilerplate entry/exit code, and provides enhanced ASCII/EBCDIC translation.
GUMFWEB - Utility	OSES	This is the controller for CICS calls.
GUNPUC/GUNSCHIP	OEEAS	Common modules used to query SSNs real-time
Health Information Technology	ODS	
Health information Technology management information	OASSIS	Health IT MI, an automated MI system is the tool that will provide data analysis to monitor the work loads and provide trend analysis and information on a variety of variable such as time and location. HIT MI provides users with information to make further improvements and enhancements to the disability process.
Health Information Technology Web Services Interface	OSES	The HITWSI application provides a transport mechanism to request and receive medical information for the purpose of adjudicating SSA disability claims
Help America Vote Verifications	OEEAS	SSN verification for voter registration via MVA's
Help America Vote Verifications MI	OEEAS	Provides MI on information processed in the HAVV system.

Application Information Report

Name	Owner	Description
HP Asset Manager	OTSO	COTS based software application derived from HP Asset Manager. Provides IT Asset Management for the physical, financial, and contractual data of all OTSO managed IT Assets.
HP Service Manager	OTSO	The operating system for the Change, Asset and Problem Reporting System (CAPRS) is Hewlett Packard Service Center v.6.2.
Human Resources Operational Data Store	OEEAS	HRODS is a mainframe DB2 database housing employee and position data, mainly created from the Dept of Interior's FPPS. The major function of HRODS is to respond to management requests and legal and Congressional inquiries. Reporting ability is distributed through Oracle EPM (formerly Hyperion). HRODS data is accessed by many other systems.
i1020 Medicare	OSES	Use the internet to apply for Medicare Prescription Drug Plan
iAppointment	OSES	The Online Appointment Scheduler (iAppointment) is an application that will provide public users of the Social Security Administration?s (SSA) Internet services an avenue of scheduling an appointment with a field office online.
IBM Tivoli Monitoring	OTSO	Monitoring suite -- including TEPS, ITCAM for AD, Omegaview as well as Omegamon agents on z/OS & Distributed (for monitoring z/OS, WMQ, DB2, CICS and WAS)-- -IBM Tivoli Management Services -IBM Tivoli OMEGAMON DE on z/OS - IBM Tivoli OMEGAMON XE for CICS on z/OS - IBM Tivoli OMEGAMON XE for CICS TG on z/OS -IBM Tivoli OMEGAMON XE for DB2 Performance Expert on z/OS -IBM Tivoli OMEGAMON XE for Messaging on z/OS -IBM Tivoli OMEGAMON XE on z/OS & Dist -ITCAM for Application Diagnostics on z/OS & Dist -ITCAM for Transactions for z/OS
iClaim	OSES	Allows the public to complete retirement, spouse and disability applications on the Internet. Provides status of claims field via the Internet and MCS claims where the claimant has requested a confirmation number.
IENP Check Core Service	OEEAS	The IENP Check Core Service is used to determine if the SSN being requested belongs to an Indivdual of Extraordinary National Prominence
iESI Proxy Authentication	OTSO	This application provides an intranet single sign on solution that leverages the ESI interactions between the ACU and non- ESI workstations to provide a login to iESI enabled applications. It also allows the ACU to mimic the iESI interaction with a browser but convert the backend interaction to Java EE rather that iESI. This provides a potential migration strategy away from iESI to more supported Single-Sign on solutions.
I-Main	OSES	The I-Main project introduces the concept of providing a centralized location for all of the SSA Intranet applications needing a security interface. This security interface menu serves as a single point of entry for SSA's Intranet applications.

Application Information Report

Name	Owner	Description
Information/Certified Earnings Record System	OEEAS	ICERS provides SSA personnel with informational, certified and totalization earnings records to assist in processing the most complex claims that are excluded from MCS and providing accurate estimates to claimants. It also processes batch HIMEX, RR Board, Quarters of Coverage Indicator(QCI), Premium HI Reduction and Transitional Employee transactions.
Instant Messaging Gateway Enterprise Infrastructure	OTSO	This is an intranet infrastructure to allow applications that reside on different platforms (WebSphere, Windows, UNIX, etc...) to send Instant Messages to Agency Users. This application is being designed to accommodate load balancing and optimize message delivery to leverage the Agency s Instant Messaging Infrastructure currently OCS 2007/Lync 2010).
Integrated Client Database System	ORSIS	The CLIENT system contains the Shared Process Menu which is accessed from the SSA Main Menu and software for some of the menu selections, specifically Evidence, Administrative Sanctions and the display of client data through CDAM.
Integrated Client Database System - Back End	ORSIS	This system has no screens associated with it. It contains all the client data access modules and the batch process necessary for tracking client transactions.
Integrated Disability Management System - CICS Mainframe Interface	ORSIS	This project supports the IDMS front end collection CICS screens for processing CDR, Earnings, Demo and Ticket to Work actions.
Integrated Registration Services	OSES	IRES provides registration, authentication and account maintenance functions for all applications contained in the Business Services Online (BSO) suite of services. IRES's main function is to control access to applications within BSO.
Integrated Registration Services Customer Service	OSES	Intranet Customer Support application of IRES
Integrated Work Measurement System (IWMS)	OEEAS	Collects and stores MI on workload counts, samples, staffing and hours.
Interactive Computation Facility	ORSIS	The Interactive Computation Facility (ICF) is comprised of the original online Title II ICF process that provides automated computational support to the Payment Centers. With T2R the online Workers Compensation (WC) portion of ICF was added.
Internet 1099	OSES	Provide an online request for a replacement SSA-1099 or 1042S (for non-citizens/non-residents). The replacement SSA-1099/1042 is sent by USPS within 30 days.
Internet 3820	OSES	Provides the public with the ability to complete the Disability Report-Child (SSA-3820) online
Internet Appeals	OSES	Provides the public with the ability to complete their Appeal(501/561) and Disability Report-Appeal (SSA-3441) online.
Internet Benefit Verification Letter	OSES	This application allows a beneficiary to request a proof of income letter over the Internet.
Internet Claims Status	OSES	Allows the public to check the status of their retirment claim on the Internet.
Internet Direct Deposit	OSES	This application allows a beneficiary to start Direct Deposit of their checks or change their current Direct Deposit to another account or financial institution via the internet.

Application Information Report

Name	Owner	Description
Internet Disability Workload Management Information System	OSES	This system displays (or prints) workload tracking listings and management summary reports by field office component.
Internet Electronic Death Registration	OSES	IEDR application is a G2G application that enables State Bureau of Vital Statistics to verify decedent Social Security Numbers (SSNs) prior to the submission of death reports to the SSA. The State is responsible for authenticating each death registration.
Internet Enterprise Security Interface	OTSO	WAS Top Secret Interface
Internet Knowledge Based Change of Address	OSES	Use the internet for your 'Change of Address'
Internet Medicare Replacement Card	OSES	Allows the beneficiary to request a replacement Medicare card over the Internet.
Internet Password Change of Address	OSES	Use the internet for your 'Change of Address'
Internet Password Check Your Benefits	OSES	Provides Title II and XVI recipients query of their account information.
Internet PIN/PASSWORD	OSES	Allows public to request a pin password via the internet
Internet Representative Payee Accounting	OSES	Application allows Representative Payees to complete accounting forms online via the internet.
Internet Social Security Statement	OSES	The ISSS process provides an Internet client for requesting delivery of a PEBES. ISSS does not produce the statement. It passes the request to PEBES for fulfillment.
Internet Special Notices Option	OSES	The iSNO application allows beneficiaries, claimants, representative payees and other individuals receiving services from this agency, to specify their delivery preference when receiving notices or other printed materials from this agency.
Internet SSN Verification	OEEAS	Web Service real time verification for Dept of State and other agencies to use to verify the SSNs of individuals. Dept of State will use this service to verify the SSNs of individuals who have submitted applications for passports.
Internet Ticket Operations Provider Support System	ORSIS	iTOPSS is the new system that is planned to replace the existing Comprehensive Work Opportunity Support System(CWOSS),Vocational Rehabilitation Reimbursement Management System (VRRMS) and the mainframe Ticket to Work (TTW) CICS screens. The new systems will allow for contract awards, ticket assignment and payments of a larger group of Employment Networks (EN).
IRMAA Statistics	ORSIS	IRMAA statistics - Provides a count of all IRMAA determinaitons, by state, by Congressional District.
Iron Data St. Louis	ODS	Supports disability case processing in all 30 Disability Determination Services. As of December 6, 2010 all 30 sites are at Release 15.
Iron Data Toronto	ODS	Supports disability case processing in 17 Disability Determination Services. 15 sites are at Release 15. Two sites remaining with production dates of 2/14/11 and 2/28/11.
Item Correction	OEEAS	Item Correction is the earnings system that enables the users of the system to correct earnings details on an individual number holder's (NH) Master Earnings File (MEF) record. Usually the NH will bring a mistake or misstatement to the attention of SSA.

Application Information Report

Name	Owner	Description
Item Correction Adjustment MI	OEEAS	The purpose of the Item Correction MI system is to support and report on the Item Correction System
Item Correction Workload Management System MI	OEEAS	This system allows management to track the item correction workload by counts that are done by subordinate offices.
IVF Core Service	OEEAS	The IVF Core Service returns data from the Intranet Verification File based on the requested PIN
JAVA Workstation Initiated CICS Server	OESAE	JAVA Workstation Initiated CICS Server
JAWS Using a Data Generated Environment	OESAE	Used by employees with disabilities to "read" CICS screens by speaking the screen contents
Journal Manager	OTSO	Sofware supports journaling for IDMS Database systems. The software is at Version 160 (v160). This is the current version.
Judicial Automated Calendaring System	ODS	InTERnet and InTRAnet web application used to support ODAR's Automated Scheduling project. This is a COTS vendor product tailored to accept input from the CPMS database and automatically schedule cases.
Labor Relations Case Tracking System	OEEAS	The LR Case Tracking System will allow managers and Regional LR staff agency-wide to input grievance information in a uniform manner
Language Development Facility	OESAE	Visual Basic based application used to enter, format and store language/text along with choices for the TNA notice formatting system. Also provides a Lotus Notes search facility used to look up notice language and choices.
Limited English Proficiency	OEEAS	This is a mainframe based application that collects and stores MI data on the different client languages for which SSA provides service. LEP data is collected weekly and used to generate yearly reports which are accessible from EMIS, an SSA intranet site. LEP data is sourced from the SUMS demographic data that is stored in the Business Intelligence Work Measurement Data Warehouse, effective 10/1/2010.
Local MI For Post Entitlement Events	OEEAS	This system provides reporting on the rate of electronic vs non-electronic provision of Post Entitlement services by servicing office and clint zip code
MADCAP Notices	ORSIS	Produces notices for MACADE/MADCAP actions using the Target Notice Architecture (TNA).
Mainframe Time and Attendance System	OEEAS	Capture and Validate Time and Attendance for all SSA employees. Transmit a data extract to Department of the Interior (DOI) every 2 weeks. DOI is the payroll provider.
Management Information & Control for Earnings	OEEAS	Provides control, tracking and MI for earnings-related initial claims workload in OCO. Provides online case control system for initial claims output requiring clerical intervention before being dispatched to adjudicative personnel in field offices.
Management Information & Control for Earnings MI	OEEAS	A workload management and tracking system used to control: earnings inquiries on initial claims, from the public or SSA FO's on pre-claims earnings.
Managerial Cost Accountability System	OEEAS	Future Releases of MCAS - Cost Accounting MI

Application Information Report

Name	Owner	Description
Mandatory Smart Card Logon Enrollment	OTSO	The purpose of the Mandatory Smart Card Logon Enrollment (MSCLE) application is to provide individual SSA users with a way to enroll their own Active Directory account in the Mandatory Smart Card Logon (MSCL) initiative. Users will be able to verify that their PIV smart card is functional and submit a web form which will enroll the logged on active directory user in MSCL. This will be done under the supervision of a SLC/Systems Administrator. Upon submission, a notification email will be sent to the Requester, SLC, and Security Officer. Once the user is enrolled in MSCLE reporting services will be available to give the number of enrolled users for each organization.
Mandatory Smart Card Logon Override	OTSO	The Mandatory Smart Card Logon Override (MSLO) application allows individuals with administrative rights over another user (SLC s, Help Desk Staff, Global Admins, etc) to give a user a temporary exception from MSCL for various periods of time. The Administrator will be acting as the requester and submitting the web form for the affected user. This application is to be used when a user forgets, loses or breaks their card. In addition, it can also be used for temporary exceptions when a user has to be involved in a project for which they need to use an Active Directory PIN and password. Upon submitting the web form, the affected user will be removed from MSCL and their Active Directory user account will be reset. A notification email will then be sent to the affected user, the requester, and the Security Officer. The affected user s account will automatically be returned to MSCL at the end of their period of temporary exception.
Manual Adjustment Credit & Award Data Entry	ORSIS	CICS data collection sysytem for MADCAP. Interfaces with A101/M101, ICF, Rep Payee, Client, Medicare and MBR for data. A batch pprocess formats MADCAP input data and creates MBR finders.
Manual Adjustment Credit and Award Process	ORSIS	Allows for the manual processing of all initial claims and post entitlement actions that are not automated. It establishes, modifies and deletes most of the elements on the Master Beneficiary Record.
Master Beneficiary Record Payment History Update System	ORSIS	Payment History Update System. This system updates PHUS data on the PHUS. Master data is sent to the PHUS update when payments are made outside of a Post Entitlement application program (SPS, GARN, etc.)
Master File Conversion to DB2	OESAE	Convert Master Files to DB2.
Master File Duplicate Detection Operation	ORSIS	This SEMI ANNUAL Operation looks for individuals ERRONEOUSLY receiving benefits from the same or multiple account numbers. Alerts are sent to field offices for processing.
MBR Extract System	ORSIS	This system is a series of programs that provides a means for offices to request and receive selected MBR information in special formats based on a match of provided data. This is part of the PE search.

Application Information Report

Name	Owner	Description
MBR Select System	ORSIS	This system selects from the MBR: 1. Files for deletion of certain beneficiary special payments. 2. Files of cases with overpayments in the special payment amount field. 3. Files of beneficiaries subject to an increase in benefits due to an adjustment of Reduction Factor/Delayed Retirement Credit.
MBR Update Maintenance Operation	ORSIS	MBR Master File Maintenance. This application deletes aged data from the MBR. A function that was removed from the MBR UPDATE (RTAPLAUD) operation when it was re-writtem to become the Monthly update.
Medical Evidence Gathering & Analysis Health Information Technology	ODS	The main objectives of the MEGAHIT prototype are to encourage the healthcare providers to establish medical records that are interoperable. Leverage the electronic standards and products associated with the large-scale HIT initiatives and gather medical information in an automated process with little or no human intervention in a timely fashion. And improve the efficiency and accuracy of the disability adjudication process.
Medicare - IRMAA	ORSIS	Imposes higher Medicare Part B and Part D premium rates on high-income earners as defined by statute. Adjusts those impositions on the basis of beneficiary allegations. Verifies the accuracy of those allegations.
Medicare Accounting System	ORSIS	End of Month operation that sweeps the Medicare Database and sends the amount of Part C and D benefits wihheld by SSA that are to be transferred to CMS.
Medicare Application Processing System (MAPS)	ORSIS	Medicare Part D Low-Income Subsidy Application taking process. Consists of Websphere screens and includes resolution of exceptions received via paper and internet intake process.
Medicare OCSE Data Exchange	ORSIS	This data exchange supports the Medicare Part D Low Income Subsidy Determination process. This exchange obtains current earnings, self employment and unemployment income.
Medicare Operational Data Store	ORSIS	Provides detailed data and IWMS and SUMS counts for both Medicare Part D Subsidy Applications and Medicare Part B and Part D IRMAA. Also provides Receipt, Pending, Clearance, Completion Listings and SSN Query capability for Medicare IRMAA (which includesPart B & D) via MI Central.
Medicare Part D and C Premium Collection	ORSIS	The premium collection and processing function begins when a Medicare beneficiary enrolls in a Part C or Part D plan and elects that the premiums be deducted from his/her Title II check.
Medicare Part D Deeming	ORSIS	Awards 100% Part D subsidy awards based on transactions from CMS
Medicare Part D Screening	ORSIS	The Medicare Part D Screening process screens new Medicare Attainers or Enrollees to determine if teh beneficairy is below the Federal Poverty Level.If the benefiary is below the Federal Poverty Level the screening process builds a notice queue row to send an SSA-1020 application for Prescription Drug Extral help.
Medicare Part D State LIS	ORSIS	Awards Part D subsidy awards based on transactions from states.
Medicare Part D Subsidy	ORSIS	This application determines if a low-income subsidy can be processed for Part D Medicare prescription drugs.

Application Information Report

Name	Owner	Description
Medicare Query	ORSIS	Intranet query which displays Parts A,B,C, and D application data.
Medicare Savings Plan Data Exchange	ORSIS	Implements PL 110-275 changes in the way Low Income Subsidy (LIS) applications are processed.
Medicare Selections	ORSIS	Daily and Monthly Medicare selections from the MBR.
Medicare SSI Deeming	ORSIS	This application creates potentional SSI deeming records and transmits them to CMS, on a weekly basis, using the SSI Effective date, the Medicare Eligibility date and MBR data to build periods of pottential SSI Deeming
Medicare Workload Management	ORSIS	Provides Pending Listing, Filter Capabililties, & Bulk & Single Transfer Capabilities
MEF Earnings Update System	OEEAS	Update and maintain earnings database for use by other systems and provide earnings totals to actuary.
MESODS GREP Interface	OSES	Interface used for applications where detailed MI data is stored in the MESODS database and the Generic Reusable Extract Program (GREP) is used to pull numbers from MESODS to provide balance and logging information in MSHARE common balance and logging tables.
MI Electronic Services Operational Data Store API	OSES	The MESODS API consists of a set of routines, protocols and tools for eServices applications to write information to the Electronic Services Operational Data Store (MESODS) DB2 database instead of the Common Internet Backend Audit (CIBA) Traffic File.
MI for Appointed Rep	ORSIS	Management Information for appointed Rep reads the MISF copy of the Appointed Rep database and the MISF copy of the Single Payment system database and accumules a count report for display on the MISF.
MI for Debt Management System	ORSIS	Provides Debt Management screen counts
MI for ECO	ORSI5	Provides management information for the External Collection
MI for Garnishment	ORSIS	Provides totals via CICS for the online Garnishment System
MI for Monthly Consistency Check	ORSIS	This project receives admin records from the Claims System End of Month Operations (CSENDOP) which are processed in the PCs on a monthly basis. Three types of actions are received: Original Awards, Terminations, and Credit Adjustments. Several tabulations are prepared for the Office of Requirements, Evaluation and Statistics (ORES) from unedited data. The records are then processed through an extended editing and auto-correction procedure monthly, producing an exception file and tabulations showing the types and frequency of errors.
MI for Post-Entitlement	ORSIS	Provides Post Entitlement Management Information at the SSN level
MI for RECOOP	ORSIS	Provides monthly and year-to-date totals from the RECOOP system
MI for Tax Levy	ORSIS	Provides totals via CICS for the online Tax Levy System
MI Single Payment System	ORSIS	Read the DB2 SPS database on the MISF and format and display dynamic reports on EMIS server (Intranet).

Application Information Report

Name	Owner	Description
MI Social Security Number Verification Service	OSES	Management Information for SSNVS. SSNVS allows employers to match their record of employee names and SSNs with Social Security records before preparing and submitting W-2 Forms. Making sure names and SSNs on the W-2 match our records is important because unmatched records can result in additional processing costs for employers and uncredited earnings for their employees.
Military Service Reimbursement	OEEAS	To generate a Primary Insurance Amount (PIA's) for persons with and without military service during the period of 1940-1956
Mobile Technologies for SSI Wage Reporting	OSES	MKWR is a hybrid application (leverages the functionality of the smartphone's native web browser inside a downloadable application as the target application platform for transactional eServices applications) that allows SSI recipients, deemors, and representative payees of SSI recipients to report gross monthly wage amounts that a wage earner was paid in the previous month, using a mobile device.
Modernized Claim System - Data Collection	ORSIS	MCS DC is a set of data collection screens which collect all the information needed from a claimant to process the claim to pay. Some of the information collected is marriage and child data, recent earnings, military or railroad service, and Medicare enrollment.
Modernized Claim System - Earnings Comp	ORSIS	MCS Back-end is known by the users as the Earnings Comp (EC) process. It is initiated by a transaction entered off the MCS Menu after the MCS Front-end data collection screens are completed.
Modernized Claim System - Management Information	ORSIS	The Workload Management System for Initial Claims (WMS/IC) tracks Title II initial claims from their entry into the Modernized Claims System (MCS) by recording either the specific events in a claim's life cycle or the tasks performed for the claim.
Modernized Claim System - Notices	ORSIS	Produces notices for MCS actions
Modernized Development Worksheet	OASSIS	Modernized development worksheet.
Modernized Earnings Integrity Review System	OEEAS	Targeted criteria for review by security staffs to ensure the security and integrity of the Earnings Item Correction process.
Modernized Integrated Disability Adjudicative System	ODS	Supports disability case processing in Disability Determination Services offices (Alaska, California, Delaware, Guam, Missouri and Virgin Islands),Western Payment Service Center, Dallas DPU, North East PSC, Mid Atlantic PSC, South East PSC, OCO FDU, OIO, Great Lakes PSC, and Mid America PSC.
Modernized Online Edited Transactions	ORSIS	MONET is a CICS system that collects data for updates to the Master Beneficiary Record. MONET does not maintain files. MONET writes 3 types of Traffic records to the Traffic file.
Modernized Overpayment Underpayment Report System	OASSIS	MOURS is a Title XVI Reporting application. It is an over/under payments reporting system. MOURS gathers financial information used in developing reports for Finance (Schedule 9). Reports are sent to the Treasury Department.

Application Information Report

Name	Owner	Description
Modernized SSI Claims System Workload Management System	OASSIS	These programs capture data online (real time) during the MSSICS claims taking process. This data is stored in an IDMS database. In addition, some data is obtained in batch mode and updated to the WMS record overnight.
Modernized Supplemental Security Income Claims System	OASSIS	SSI Claims-Taking and Update Process
Month of Election Service	ORSIS	Month of Election Service (MOE) will derive the MOE options presented to a user. This includes the default MOE date and a range of other possible dates. After the user has selected an MOE date from the provided choices, the service will determine the MOE .
Monthly Financial Accounting System	OASSIS	Creates a file of all SSI accounting transactions that is sent to each state on a monthly basis.
Monthly MBR Total System	ORSIS	CSPOT interrogates the MBR to provide the users with requested information about beneficiaries. CSPOT is run monthly around the 16th of the month after the monthly MBR update.
Monthly MBR Update System	ORSIS	Master File Update merges MBR ORBIT to the previous month MASTER file to create the Current months MASTER and creates beneficiary payment records for reformat and transmission to Treasury.
Monthly Update System	ORSIS	Provides monthly updated MBR's (LIMITS) via online retrieval system
MULTX Database Update	OEEAS	The system updates the file of cross-reference SSNs.
My Social Security Application	OSES	The overall purpose of the MySocialSecurity project is to provide a personalized Internet portal that will be a viable self- service alternative to our telephone and in-person service. Services via the MySocialSecurity portal will be available to the entire Social Security Administration s (SSA) customer base (i.e. non-beneficiaries, beneficiaries, representative payees, etc.) that have registered and authenticated via Registration of Most Everyone (eAuthentication). The portal will encourage self-service by providing an easy to use, dynamic environment that encompasses the full spectrum of agency services. MySocialSecurity will also serve as a platform to inform the public about changes, new online services, new regulations and mandates that affect them. In addition, the portal will offer full immediate online customer support to encourage users to remain online, including video tutorials, FAQs, and two-way communications like click to chat and secure email. This project aligns with the agency s service strategy by providing the user a transparent, comprehensive and consolidated view of information, with access to multiple SSA services via the portal.
My SSA Tab Service	OSES	A web service that will be invoked by the My SSA application to determine which tabs to display to ROME registered/authenticated customers based upon user roles. Roles are the tab display codes from the application and are used in determining which tabs will need to be displayed. MSTS will be deployed using the OSES standard z/OS, Solaris deployment scripts. MSTS is a RESTful service accessible from any platform capable of making a Hypertext Transfer Protocol (HTTP) call. It will not have any PII, login, security fields, and an XML format will be used.

Application Information Report

Name	Owner	Description
My Time and Leave	OEEAS	Web based access to Leave Balance and Hours Worked and Absent Reports. Available to all SSA employees.
mySSA Change of Address	OSES	Public Change of Address request; this application is part of the "My Social Security" suite of client applications.
mySSA Check Your Benefit	OSES	Public Check Your Benefit; this application is part of the "My Social Security" suite of client applications.
mySSA Direct Deposit	OSES	Public Change of Direct Deposit request; this application is part of the "My Social Security" suite of client applications.
National Disability Determination Services System	ODS	Automated system providing case control and management reporting support for disability claims.
National Docketing Management Information System	ODS	An Intranet application that tracks Litigation Cases denied by OHA that are now assigned to OGC. COTS-based. It runs on a UNIX Solaris Server. Data is stored in Oracle database.
National Vendor File Management Application	ODS	An intranet based application which consists of a consolidation of all disability vendor data repositories. The Client will search for providers of medical information via a robust search appliance that displays the results of relevance, and presents data in a logical, well organized, and easy to read format
National Vendor File Web Services	ODS	Consolidation of the DDS legacy vendor files which contain medical providers and other vendors that support its disability processes and applications into centralized, service based, data store. The web services provides the tools and functionality required to support the data requirements for case processing.
Nebraska DDS	ODS	State developed legacy system used to process disability cases.
New York DDS	ODS	State developed and maintained application used to process federal disability cases.
Nightly Earnings Search	OEEAS	To provide earnings information from the Master Earnings File to requestors from Title II systems (Enforcement and Bendex) and the Office of Child Support and Enforcement (OCSE)
Non-disability Repository for Evidentiary Documents	OESAE	Provides a means of electronic capture and storage of non system-generated artifacts (related to claims files) in the Non- disability DMA Repository.
Notice Counts for IRMAA	ORSIS	Provides totals of IRMAA notices
Notice Counts for T2R	ORSIS	Provides totals of T2R notices
Numident Online Verification Utility	OEEAS	Used by various applications to access NUMIDENT real-time
Numident Quarterly Update	OEEAS	Updates the NUMIDENT master files.
OCSE Real Time Query	OCSE	Query the wage file for OCSE. Have System's Requirements. The query will run regardless of whether OCSE participates or not. It just won't return any data if OCSE does not participate in the DR. Empty screens, field reverts to batch listings.
OCSE Request Service	OASSIS	This is a webservice created to provide OQP and the Regions with NDNH data when requested. The user will make a request for NDNH data, the app will go to OCSE's webservice, retrieve the information and return it to the user via the OCSE Request Service application.

Application Information Report

Name	Owner	Description
OCSE State Wage Alerts	OCSE	The OCSE database is accessed for the purposes of extracting data for Title XVI claimants who may have earnings for specific periods of time. If individual is located after tolerances are applied, alerts are generated to field offices for investigation.
Office Lookup Core Service	OEEAS	The Office Lookup Core Service provides Office Information from DOORS based on the requested Office Code
Office of Child Support and Enforcement	OCSE	Support OCSE initiatives
Office of Hearing and Appeals Case Control System Reports	OASSIS	Produces OHA reports on a monthly and quarterly basis.
Official Union Time Tracking System	OEEAS	Capture and Validate Official Union Time worked by AFGE Union Representatives. Produce MI reports of Official Union Time.
OHA Case Control System	ODS	Supports ODAR workloads, old legacy application to be retired by the end of FY11 as part of Continuous Availability project.
One Percent Treasury Refund	OEEAS	The 1% treasury Refund system runs annually to produce Error and Legacy Treasury information data for required previous years. Data is sent to ORES for report preparation.
Online Retrival System	OESAE	ORS stores a copy of a notice that is sent to number holders (NH) which the field (SSA Users) can retrieve to help in answering questions in interviews or phone calls. The field can also request a batch reprint of the notice to send out.
Online Social Security Statements	OSES	Allows the user to access the Social Security Statement information online. Provides the capability to access a formatted PDF of the Statement and change delivery preference (online or U.S. mail) for Statement data. The system will also send an automated email reminder on a yearly basis to remind the user to check their Statement information online.
Online Software Release Form System	OTSO	System to sponsor and track SSA software changes.
Online Suspense Reinstate (Menu Option 3)	OEEAS	Allows user to reinstate W2 items without going into ICOR. Designed for a clerical that is working on an employer level not an individual level. This uses the same code as the suspense query/reinstate that is used in ICOR.
OPM Catch 62 Match	ORSIS	PSMIRPS is the major system that receives the file for the OPM Catch 62 Match file. PSMIRPS module E1845V3P that processes this file provide Military credit info to OPM.
OPM/GPO - WEP - PDB	ORSIS	CSWEPRMN and CSPDBRMN produce an alert file for XEROX for certain beneficiaries who receive both disability and /or retirement benefits and a civil service pension. CSGPORMN produces an alert file for certain beneficiaries who receive RSI benefits.
OPM/MBR	ORSIS	PSMIRPS is the major system that receives the file for the OPM/MBR Medicare Match. Module E1851V1P that processes this file is an annual job to provide MEDICARE info to OPM.

Application Information Report

Name	Owner	Description
Output Service User Requested Earnings	OEEAS	Produces the 1826 reports of all requests sent to it by EMISER. Gathers and assemble the info into a print report file using the details found on the MEF as arranged per Employer (from the EIF) by the year(s) for which the info was requested.
Overpayment Control Non-Entitled Debtors	ORSIS	Creates updates to repository (NED data base) for overpayment owed by recipients (REPAYEES) not receiving benefits
Paperless Infrastructure and Utilities	OESAE	Includes the Route, Workload Transfer, Archive, and various COTS packages
Paperless Processing Center Batch	OESAE	Batch programs that transfer data, process COLD and replicate for the enterprise
Paperless Processing Center Client Workstation	OESAE	Paperless tracks, monitors, moves, holds and archives pending and completed actions, receiving input from mainframe print streams in PDF format, faxed and scanned images, eforms and imported Word and Excel documents.
Paperless Under DMA	OESAE	Paperless is an Action Management system. This application is a re-write of the current Paperless Processing Center application. The first release will only be a partial replacement, providing barcoding functionality and manual indexing.
Paperless Under DMA - Archive Migration Utility	OESAE	This utility copies documents from the PPC G360 archive servers to the DMA repository and notifies CFRMS. It is temporary until R1.3 of Paperless.
Parent Locator System	OEEAS	Parent Locater System to identify parents involved in child support cases
Part B IRMAA Notices	ORSIS	Produces notices for Medicare Part B System actions
Part D Subsidy Notices	ORSIS	Produces notices for Medicare Part D system actions
Password Service	OSES	
Payment History Corrections Subsystem	OASSIS	CICS Process for correcting payment history when discrepencies arise between OBASA and Systems.
Payroll ODS Correction Facility	OEEAS	Allow for the correction of PAYODS data received from DOI
Payroll Operations Data Store	OEEAS	To load the Department of Interior (DOI) Accounting Feeder file to the Payroll ODS DB2 tables.
Performance Assessment and Communication System	OEEAS	The system assists supervisors in preparing employee performance plans, documenting expectations and progress reviews and preparing performance appraisals.
PING	OESAE	Ping service provides a generic interface program to receive WebSphere initiated requests to check specified CICS regions and assets for availability. It accomplishes this task by reading an application level ping descriptor from the ping control file. It links to the programs specified in the ping descriptor in the regions specified in the ping descriptor.
PolicyNet	ORDP	
Position Data Application (PDA)	OEEAS	The system assists DCHR classification staff to enter position data directly into HRODS.
Post Eligibility Operational Data Store	OASSIS	This system tracks redeterminations and Limited issues for the agency. It has a DB2 database with a WEB front end. MSSICS information and SSR information is used to build the DB2 database (PEODS)

Application Information Report

Name	Owner	Description
Post Entitlement MI	OEEAS	The Postentitlement Management Information (PEMI) Project was eveloped as part of the Program Benefits Modernization Project, to address the PEMI needs of users throughout the SSA community. PEMI provides detailed and aggregate receipt, pending, and clearance data, as well as other strategic and tactical MI for many Title II and Title XVI PE transactions processed in SSA field offices (FO's) and processing centers (PC's). The data enables SSA managers to make decisions regarding SSA staffing, budget, training, work allocations and workflow control. The programmatic system sources from which PEMI obtains PE data include: CICS Traffic (CICS), Debt Management (DM), Modernized Claims System (MCS-1818s only), Modernized Data Input (MDI) System, Modernized SSI Claims System (MSSICS), Postentitlement Online System/Workload Management System (POS/WMS), Representative Payee System (RPS), Representative Payee Accounting (RP-ACCT), Prisoner Tracking Management Information (PTMI) system, Processing Center Action Control System (PCACS), Internet Transactions, Miscellaneous Online Edited Transactions (MONET). Further information can be obtained from the MIM chapter 9600 for PEMI.
Post Entitlement Online System	ORSIS	Postentitlement Online System (POS) handles Title II event changes following entitlement to benefits.
Post Entitlement Print Environment	ORSIS	PSPEPE is the Post Entitlement print program operation. The PEAT records communicate actions the object programs have taken that affect and update the MBR. These records are used by PSPEPE to produce folder documentation.
Post Entitlement Search Operation	ORSIS	Master File Search associates application transaction records with the latest MBR. Prioritizes transactions for delivery to Post Entitlement Application Programs.
Predictive Model	ODS	Called utility for Quick Disability Determination (QDD) - developed by IBM - used by EDCS to "score" initial disability cases to predict if a quick determination can be made by the DDS.
Prism	OESAE	The SPMT will provide a framework for using one application to define and track every aspect of projects and portfolios. It will incrementally be implemented to replace or integrate with existing tools such as VISOR, SPARS, RIMS, etc. SPMT will provide Project Management functionality such as creating IT proposals, moving proposals through an approval process, conducting what if scenarios, managing project schedules, tracking project risks, reporting project status via dashboards, tracking progress against the plan, accessing and updating documents, generating reports, etc.
Prisoner System	ORSIS	Track Prisoner to see if they are receiving benefits. If so alert claims personnel to stop the benefits.
Prisoner Tracking MI	OEEAS	Provides Prisoner MI for field office receipts, pending and clearances. Also provides MI on prisoner submissions and incentive payments.

Application Information Report

Name	Owner	Description
Processing Center Action Control System	ORSIS	PCACS is an online, interactive National case control system (i.e.,workflow system), used by the PSCs, that controls and tracks PSC actions, diaries and folders, including programmatic actions generated by various claims and PE processing systems. It also provides enhanced and consolidated management information.
Processing Center Action Control System Work Sampling	OEEAS	The Processing Center Action Control System Work Sampling (PCACS) tracks actions, via sampling, to determine the types of activities and actions performed in the Processing Centers. The resulting data of Samples and Rosters is then sent into the Processing Center Management Information (PCMI).
Processing Center Management Information	OEEAS	PCMI is a legacy work measurement system for the processing centers. It captures and stores workload counts from the Processing Center Action Control System (PCACS) and work sampling tallies from PCACS Work Sampling (WS) System and stores the data in DB2 database. The data is used to generate MI workload reports by processing center.
Project Tracking System	OTSO	PTS is used nationwide to schedule and track the progress of OTSO's hardware and software refreshment projects.
Public Information Request System	OESAE	WebSphere based application that allows the TSC and FO personnel to request forms/pamphlets on the public's behalf. These pamphlets are printed by print contractors. Verizon provides the automated telephone request process.
Quality Assurance Systems Message Router	OASSIS	JAVA based utility that provides communication between the Electronic Folder and DICARS/DQR application.
Quality Performance Management System	OEEAS	Provides multi dimensional view of quality performance measures
QUERY	ORSIS	Queries of various master files are returned to the screen or sent to a printer. Queries just read the data and display the information. (ie. Bankshot, HI, IR, PHUS, SEID, THIS). ORSIS does not own all queries in this Endevor System.
Race & Ethnicity Collection System	OEEAS	Collects Race/Ethnicity data from initial claims applications using OMB standards and creates extract and MI report for statistical analysis.
Railroad Retirement Audit	ORSIS	These CICS screens are used by the Railroad Board to provide SSA with payment Trust Fund information.
Railroad Retirement Audit for Batch	ORSIS	Railroad Board Audit matches SSA payment information from the MBR and Critical Payment systems to payments actually being made by the Railroad Board.
Railroad Retirement Board - Joint Agency Data Exchange	OEEAS	This is an online system that formats a request to obtain a social security MBR directly from SSA. This information is used to calulate the railroad tier 1 portion of the annuity. The JADE system is a direct real-time, data exchange communication link between several RRB application systems and SSA's mainframe.
Rates Utility for T2	ORSIS	Computes the monthly benefit amount (MBA) for T2 beneficiaries for IC and PE.

Application Information Report

Name	Owner	Description
REACT Edit Input Transactions	ORSIS	Validates transactions for check debits and credit, payment over cancellation (POC) and checks over 14 months old. RCEDIT validates formats, rejects invalid data and creates a daily report.
REACT Monthly Report	ORSIS	Returned Check Hold Check Monthly Accounting Report
REACT Notices	ORSIS	Produces notices for REACT System actions.
REACT Reconciliation Input	ORSIS	RCRECKIN receives files from the Departmeny of Treasury (DT) containing EFT intercepts, hold checks, return checks and unavailables. RCRECKIN edits and balances the input files. The records are reformatted and sent to RCREACT.
Recovery and Collection of Overpayment System	ORSIS	Bills and controls Title II and Title XVI debts for terminated beneficiaries/recipients.
Recovery of Overpayments Accounting and Reporting System	ORSIS	Update and control Title II and Title XVI overpayments, Trust fund Journaling (Accounting), Beneficiary Notices and Folder Documentation.
Remittance Process	ORSIS	Part of DMS. Processes remittance data from an automated scanning process in the MATPSC as well as data keyed via DMS screens to produce records for update to the Title II, Title XVI, RECOOP and ECO systems.
Rep Payee Accounting	OASSIS	To control mailing and receipt of T2 and T16 accounting forms
Rep Payee Accounting Exceptions	OASSIS	controls development of questionable information on RP
Rep Payee DO Workload Report	OASSIS	RepPayee WMS listings and queries.
Rep Payee Management Information	OASSIS	MI reports.
Rep Payee System	OASSIS	Controls Rep Payee processing for Title II and Title XVI beneficiary payments
Report Correction	OEEAS	RCOR performs blanket corrections to employer reports (W3) where the same information (like the EIN or report year) is incorrect on every individual report (W2) within the employer report. These corrections are reflected on the MEF.
Report Correction MI	OEEAS	Produces MI summary reports reflecting activity in RCOR front end.
Report Office Table	OEEAS	Provides office hierarchy information for numerous MI Central and other applications
Resource Accounting System/Mainframe Time and Attendance System	OEEAS	Allows for the capture of DCS employee hours charged to ITAB approved projects.
Retirement Estimator	OSES	This application tool allows the public to come in via KBA authentication and do estimates of their possible retirement income. The application will also allow those users to get their estimates in Spanish.
Returned Check Accounting Report	ORSIS	This daily system performs accounting functions and produces daily and monthly reports. The daily reports show the debit and credit reporting for the day.
Returned Check Action	ORSIS	Sends non-receipt, stop payment and photo copy requests to Treasury; processes accounts receivable items from Treasury, PC's and Field Offices (FOs).
Revised Adult Disability Report	OSES	Provides public and third-party users with the ability to complete the Adult Disability Report (SSA-3368) online.

Application Information Report

Name	Owner	Description
Revised Earnings Adjustment Process	OEEAS	REAP handles earnings adjustment workloads which cannot be processed through other automated systems. These include, but are not limited to, the W2C process, 7010 offsets, the Itemized Correction (ICOR) and Report Correction (RCOR) systems.
ROAR Pending List	ORSIS	Debt Management ROAR Case Selection totals
SALT Notification of Change	ORSIS	SANOC receives daily files that originate with financial institutions that are sent to SANOC from the Federal Reserve Bank through Treasury with direct deposit enrollments and corrections. SANOC builds batch files that are sent to T16 for update of the SSR and to T2 for update of the MBR. In addition, when a date of death is updated to the MBR for a T2 beneficiary with direct deposit, DUDEX sends a file to SANOC which in turns sends a notification back through Treasury for delivery to the financial institution. This communication serves as notification of the death of the beneficiary and the bank uses this information to close out the bank account.
SASRO Activity File	OSES	The SASRO AF project enables SSA to view the MI and WMI for SASRO transactions in the Dallas Region. SASRO AF captures the number of successful and failed requests on SASRO transactions to determine what information SSA users access
Screen Enforcement Recomp Finders	ORSIS	Search of the MBR and Earnings MULTX databases for claimants receiving multiple benefits from the respective systems. Matches are alerted and sent to Enforcement Operations for possible benefit enforcement.
Section 508 Major-Purchase Wizard	OSES	This Wizard is intended to help a Contracting Officer Technical Representative (COTR) account for accessibility in purchases greater than $3,000. It is used to create the required Section 508 Compliance Form for SSASy that a Contracting Officer (CO) will be responsible for reviewing.
Section 508 Micro-Purchase Wizard	OSES	Supports 508 determinations for micro-purchases
Section 508 Testing Wizard	OSES	Supports Defect Reporting for Section 508 Compliance Evaluations
Section 508 Undue Burden Wizard	OSES	Supports routing of approvals for Section 508 Undue Burden Waivers
Secured Messaging	OSES	Secure Messaging is a common component developed to allow SSA Agency representatives to communicate securely with other state and government representatives, as well as medical providers.
Self Employed Adjustments	OEEAS	The function of this system is to adjust the earnings records for self-employed individuals who have had the wages adjusted as a result of an IRS action (i.e. audit, etc.)
Self Employed Wage Reporting	OEEAS	The SEWR application is used to ensure that the earnings and wage data of self-employed individuals received from IRS is converted into a useable format and passed on as input to the Employer Balancing System for processing.

Application Information Report

Name	Owner	Description
Service Request System	OESAE	The Service Request (SR) System is an electronic replacement for the SSA-251 form. The application provides a means for ensuring requirements and related validation material have been documented and approved for a release. Features include: - electronic signatures for accountability - email notifaction - connection to the Validation Planning System (VPS) - report capability - search capability The application also interfaces with QA2 to obtain System Certification Release (SRC) for the release.
Single Payment System	ORSIS	The scope of the SPS project is to provide a national system that will automate attorney fee payments and other Title II payments that cannot be made through the current Title II system. The national SPS system will consist of both online and batch processes.
SNO (Special Notice Option Delivery Architectures)	OESAE	Architectures that support a process to gather and transmit all SSA notices that require an alternate format (braille, audio, CD Lg. print. These architectures process and tranmit SSA notices nightly to a contracted vendor for processing and mailing.
SNO Document Checklist Management	OSES	system tracks accessibility validation of production notices created in alternative formats requested by blind and visually impaired beneficiaries.
Social Security Access to State Records Online	OSES	SASRO is an automated data exchange between state agency (HS, WC, VS, WC) and SSA employees. Authorized SSA employees query state benefit information to ensure that proper SSA benefits are paid to its recipients.
Social Security Number Application Process	OEEAS	Enumeration application collection system.
Social Security Number Long Term Fraud MI	OEEAS	Provides MI on numbers of cases detected in the programmatic SSNLTF system.
Social Security Number Verification Service	OSES	A social security number verification service for employers and third party to verify SSN for wage reporting purposes,
Social Security Number Verification Service (OEEAS)	OEEAS	Allows employers to verify name/SSNs for wage reporting purposes.
Social Security Number Verification Service MI	OEEAS	The SSNVS MI provides summary information for the Internet SSNVS application. This system includes the following MI approved architecture; 1) A mainframe DB2 relational database, 2) Standard reports created on an OTSO server, 3) Brio Enterprise Server.
Social Security Online Accounting and Reporting System	OEEAS	SSA accounting system
Social Security Online Verification	OEEAS	SSOLV is used by state Motor Vehicle Administrations to verify SSNs before issuance of a drivers license or identity card.
Social Security Statement	OEEAS	Social Security Statements are sent to workers 25 and older and not in pay. The Statements include earnings history and estimates of the Social Security benefits workers and their families can expect to receive.
Social Security Statement MI	OEEAS	Tracks SSA-initiated and On Request statement counts broken down by records sent, demographics, WEP-GPO, and manual review. Reports are presented as weekly and calendar month on EMIS for management use."

Application Information Report

Name	Owner	Description
Special Disability Workload	OASSIS	This application processes the Special Disability Workload Control File. The DB2 SDW Control File is updated daily with data from T2 and ZSCIDE. The SDW Control File is used to generate an alert on the MCS screen when a case has been added to the Control File.
Special Notice Option (SNO) Indicator Web Service	OESAE	The SNO Web Service provides a mechanism for applications to retrieve SNO information. The service provides the following two operations: Get Basic Information for Self: Used to retrieve SNO information based on a claimant account number (COSSN). Get Basic Information for Other: Used to retrieve SNO information based on a number holder s Social Security Number (NHSSN) and a beneficiary identification code (BIC).
Special Notice Option MI	OEEAS	This application will fill the need for an overarching stategy that follows delivery of notices in Braille, MS word files, CD, Printed, Certified Mail.
Special Wage Payments	OEEAS	This system adjusts the Special Wage Payment (SWP) field on the Master Earnings File. The SWP is an amount paid by an employer (or former employer) to an employee for services performed in a prior year or years.
SSA - Treasury Interface System	ORSIS	RCDISP is part of the REACT system that handles returned checks for SSA. It maintains orbit files which keep track of the Non-Receipts, Photocopies and Stop Payments processed by RCREACT. RCTRIP file updates the status of the NR's, PHC's and SP's by processing center codes.
SSA Access State Records Online Arkansas Department of Human Services	OSES	SASRO ADHS is an automated data exchange application between SSA and Arkansas Department of Human Services. This exchange follow standard Data Exchange agreement. The application allows authorized SSA users to obtain the state information during benefit interviews.
SSA Access State Records Online Webservice	OSES	SASRO is an automated data exchange between a state agency and SSA for the purpose of providing authorized SSA employees access to state agency benefit information.
SSA Claims Control System	ORSIS	SSA Claims Control System was developed to track status of claims taken and also began to be utilized as a means to provide data used as a basis for Mgmt Information about those claims.
SSAlerts	OTSO	Desktop alert/notification application
SSAMIS - Fast Track	OEEAS	Provide MI data on workload counts, samples and work hours to the regions and central office
SSI Case Control System	OASSIS	Manages physical case folders (national)
SSI Central Office / District Office (CO/DO) Communications	OASSIS	Sends Rejects & Alerts to the field
SSI Claims System - Web	OASSIS	SSI Web contains functionality that has been migrated from CICS MSSICS application. For AFI Release 1 the Resources: Finanical Institution Account (RFIA) screen was migrated to this application.
SSI CMMS Interface (T19)	OASSIS	Data Interface between SSA/SSI and CMMS
SSI Computations Subsystem	OASSIS	Calculates monthly payment amount for each SSI recipient; balance records for overpayment/underpayment errors.

Application Information Report

Name	Owner	Description
SSI Daily Edits	OASSIS	Edits SSI Inputs online and batch programs. Online in DEVVAL/DEMS/SXVIR3 and batch in TITLE16/SSICORE/SSImmmyy
SSI Daily Input Transactions	OASSIS	This application inputs transactions from T2 (i.e. BACOM/DUDEX), and Numident. The transactions are input daily. This function starts the SSI daily CUTOFF. The transactions are editted and reformatted into the T16 DSPE standard format and input to the batch PE and IC update functions.
SSI Diary Extracts for ROs	OASSIS	Produces diary files on the MISF that are fed to ChiNet for use by the Chicago region for diary listings. Also provides an online VSAM file for the WMI diary listing requests.
SSI DOL Interface (Black Lung)	OASSIS	Black Lung data is input monthly from the Department of Labor via Connect Direct. Black Lung data is used to create DSPE Transactions. Once the DSPE transactions, OVE, are built, these transactions are input to the SSI daily cutoff to be updated to the SSR Master record. Black Lung transaction data is updated to the SSR. Unearned income entries are built to the SSR and Black Lung data is updated to the MSSICS Pending File.
SSI ePath	OASSIS	SSI ePath is a web-based intranet system developed for a specific MSSICS path for non-Title XVI employee specialists (i.e., Service Representatives (SRs), Teleservice Center Representatives (TSRs) and Title II Claims Representatives (TII CRs)). It streamlines the work processes and invests in valued employees by providing them with the specialized tools needed to work with the SSI public, to complete tasks timely to determine eligibility of benefits. This project also improves world-class and public service by reducing customer re- contacts. The ability to make immediate input and updates at the first point of contact improves SSI program integrity by ultimately reducing overpayments and increasing SSI payment accuracy.
SSI Exception Control System	OASSIS	Controls exceptions arising from processing of IC Update transactions and provides information/statistical data.
SSI Felon External Interface	OASSIS	Matches SSN's submitted by law enforcement agencies through Title II with SSR Master file. Replies sent to OIG via Title II.
SSI Financial Verification System	OASSIS	Controls One Time Payments (OTP), refunds, double check negotiations (DCN), payment history changes, returned checks, and unneg checks
SSI Group Totals	OASSIS	Group Totals provide update totals of daily and cumulative changes recorded on the SSI master record.
SSI IC Update System	OASSIS	Processes SSI Initial Cliams
SSI Immigration Interface	OASSIS	The Immigration Interface Subsystem receives deporting and leaving records from Department of Homeland Security (DHS) through Enumeration Verification System (EVS).
SSI Income Service	OASSIS	The SSI Income Service is a Web Service using java and Jboss Drools to evaluate and post income data to the MSSICS database
SSI Index System	OASSIS	Indexes of the people on the SSR

Application Information Report

Name	Owner	Description
SSI IRS Interface	OASSIS	Data Interface The Wage Match (IC/WM) run occurs in Jan., May, and Sept. to update the IRS 1099 and IRS Pension data. the end of March, June, Sept and Dec. During these months IRS 1099, IRS Pension data are processed in addition to MEF, OCSE Wage and Unemployment data in Sept. Once this data is processed, diaries are posted to the SSR. They are as follows: IRS PENSION (5H) MEF (K6 AND K7) OCSE WAGE (S2) OCSE UNEMPLOYMENT (U5) IRS 1099 (5B POSTED IN REDETERMINATION RUN)
SSI Monthly and Daily Payment System	OASSIS	SSI Monthly and Daily payment operation
SSI Monthly Wage Verification System	OASSIS	Collects Wage Verification to update MSSICS and the SSR
SSI Notices	OASSIS	SSI Notices software runs in SSI Daily, Monthly Computations and MSSICS online environments. It produces input to the Target Notice Architecure system. The SSI Notice software interrogates data on old and new SSR master records to determine which type of Notices to send, who should receive them, when to send them and dynamically selects the UTIs to include in the content of the Notice.
SSI OCSE Interface System	OASSIS	Office of Child Support and Enforcement Quarterly Wages and Unemployment Data Interface. This quarterly match (Wage Match (IC/WM)) occurs the end of March, June, Sept and Dec. During these months OCSE wage, unemployment, IRS 1099, IRS Pension, and MEF data are processed. Once this data is processed, diaries are posted to the SSR. They are as follows: IRS PENSION (5H) MEF (K6 AND K7) OCSE WAGE (S2) OCSE UNEMPLOYMENT (U5) IRS 1099 (5B POSTED IN REDETERMINATION RUN)
SSI OPM External Interface	OASSIS	Processed input from OPM for income matching against SSI beneficiary records.
SSI Over/Under Payment Operation	OASSIS	Creates various reports such as IAR, Recipient Counts, 1619 A/B and
SSI Post Entitlement Rejects	OASSIS	This process creates reports of the rejects found in the SSI Batch system. This process runs daily.
SSI Post Entitlement Update System	OASSIS	Processes update transactions to the SSR
SSI Pre/Post Update Operations System	OASSIS	ZSCIDE - This function compares the old SSR to the new SSR and identifies when changes occur between the two SSRs. The SSR data is input from the NOTICES Smarts. When changes occur between the SSR data, for different components SSR data is provided according to select criteria from the component. ZSCIDE provides 28 different extracts to T2, MI, T16, Numident, SDW, CFRMS, DACUS, AJS3, OPM, and other areas. The extracts are created daily and weekly in the cutoff and according to the SSI monthly calendar.
SSI Query	OASSIS	Online and batch SSI Master record Query
SSI Redeterminations	OASSIS	Every year the SSI Redetermination system selects a subset of SSRs in current pay status to determine the accuracy of their payments and their continuing eligiblily (for non- medicalreasons).
SSI Rep Payee Accounting	OASSIS	To control mailing of T16 accounting forms
SSI State Data Exchange System	OASSIS	This system is used to exhange SSI data between SSA and the States.

Application Information Report

Name	Owner	Description
SSI Treasury/Payment System	OASSIS	Reads SSR Master file (monthly) to generate records of SSI recipients; distributes payment related change records to the SDX and the Daily FAX subsystems via the ZDF file
SSI Wilkes-Barre Folder Control System	OASSIS	Folder tracking for the Wilkes-Barre FSO and National Records Center.
SSI Workload Service	OASSIS	The SSI Workload Management Service holds workload item information for use by the SSI systems applications. The initial version is being built to support AFI Release 2 Workload Listings. This service will initially be accessed from both AFI and CICS MSSICS applications for the purpose of creating, storing, and listing work items.
SSI/DOD Interface System	OASSIS	A SSI Finder file is sent to the Department of Labor. From the finder a DOD data extract is sent back to SSA via connect direct. Once the DOD input is recieved usually the 3rd Saturday of the month (Quarterly Feb., May, Aug., and Nov.), the DOD job is triggered. An alert file is formatted for the ZOFANRED operation. And an alert file which is sorted by region, DO code, and SSN is sent to the MISF.
SSI/RRB Interface System	OASSIS	RRB data is input monthly from the Railroad Board Administration via Connect Direct. The RRB data is matched against the SSR and RRB mini records are created. The RRB mini records and RRB data are used to create DSPE Transactions. Once the DSPE transactions, OVB, are built these transactions are input to the SSI daily cutoff to be updated to the SSR Master record. RRB transaction data is updated to the SSR. Unearned income entries are built to the SSR and Railroad Board data is updated to the MSSICS Pending File.
SSI/VA Interface System	OASSIS	VA data is input monthly from the VA Administration via Connect Direct. The VA data is matched against the SSR and VA mini records are created. The VA mini records and VA data are used to create DSPE Transactions. Once the DSPE transactions, OVA, are built these transactions are input to the SSI daily cutoff to be updated to the SSR Master record. VA transaction data is updated to the SSR. Unearned income entries are built to the SSR and VA data is updated to the MSSICS Pending File.
SSN Core Service	OEEAS	The SSN Core Service provides the SSN or PIN for any employee
Standard Verification System - Batch	OEEAS	Batch system used to verify SSNs and receive NUMIDENT information in return format
Standard Verification System - Online	OEEAS	Online system used to verify SSNs and receive NUMIDENT information in return format
Standard Verification System Lite	OEEAS	Batch SVS but specifically used by the Office of Child Support Enforcement
StaRZ & Stripes - The Next Generation	OASSIS	TBD

Application Information Report

Name	Owner	Description
State Agency Work Sampling	OASSIS	SAWS information is used by the Social Security Administration (SSA) to: estimate resource needs, plan for recruitment, justify DDS budget and staffing requests, determine costs of workloads, allocate staff, access DDS productivity, estimate costs impact of legislation, track status of workloads in addition to analyzing operations, process and productivity changes. The SAWS system collects work sampling data from the DDS offices. SAWS involves sampling the activities of all DDS employees three times a day for a week for a total of 15 samples in each quarter of the fiscal year (FY). The samples are used to create monthly, quarterly and yearly reports.
State On-line Queries MI - DEMIS	OEEAS	This is an online query that provides real time responses to a State's need for SSA benefit payment information and Social Security Number verification.
State Online Query	OEEAS	Online data exchange between state agencies and SSA
State Online Query-Internet	OSES	SOLQ-I is data exchange connection between State Human Services and SSA. SOLQ-I is a web-based application via a VPN connection which enables authorized state individuals to verify Numident information and retrieve Title II and Title XVI benefit information.
State Verification and Exchange System	OEEAS	This is a batch query that provides an overnight response to a State's need for SSA benefit payment information and Social Security Number verification. SVES also provides Citizenship information from the Numident and passes records to other systems (SDX, BEER, BENDEX, PUPS, etc.) for processing.
STorage Access and Storage Handling	OESAE	The STASH service provides two operations: storing data and retrieving data. The service receives three parameters: application-shared data, non-destructive read indicator, and expiration time for the storage operation. The service encrypts the application-shared data and inserts the three pieces of information into the STASH database. The storage operation returns an identifier/key. The application calling the operation shares the key with applications that need the data. The service receives two parameters: key and non-destructive read indicator for the retrieval operation. The service retrieves the data corresponding to the key, decrypts, and returns it.
SUMS Appeals Operational Data Store	OASSIS	The SUMS Appeals Operational Data Store is a DB2 database residing on PPF and MISF. It is updated daily with data from seven data sources: SSR, MSSICS, MBR, T2ODS, NDDSS, EDCS & CPMS MI. The purpose of this database is to provide MI across the whole level of an appeal.
SUMS Data Warehouse & MI Central CDR SUMS Counts & Performance	OEEAS	This is a SUMS data warehouse application that provides SUMS Counts and Performance Measures for Continuing Disability Reviews workload.
SUMS Data Warehouse & MI Central SSI Processing Time Enhancements	OEEAS	This is a SUMS data warehouse application that provides processing time information for Title XVI Initial Claims.
SUMS Demographics and Service Area Breakdown	OEEAS	This system under the SUMS umbrella includes SUMS common modules, as well as the population of the Client Demographics and Employee Characteristic

Application Information Report

Name	Owner	Description
SUMS Earnings Operational Data Store	OEEAS	SUMS Earnings Operational Data Store
SUMS Earnings Performance Reports	OEEAS	This system provides Earnings Performance Reports via MI Central and ad hoc queries.
SUMS Enumeration MI Summary	OEEAS	Provides summary information within the MI Central Enumeration Processing Time and Performance Reports. These reports are based on data from the Enumeration programmatic system. Included in this workbook are EAB Summary Reports provided to the EAB Project Officer.
SUMS Enumeration SUMS Counts (SESC) MI	OEEAS	Provides Enumeration Workload counts via MI Central, under the SUMS umbrella.
SUMS Enumeration WMI Detail	OEEAS	Provides detailed workload management information for Enumeration transactions received from the programmatic Enumeration System.
SUMS for Post-Entitlement	ORSIS	Provides totals for the SUMS T2 PE Operational Data Store
SUMS Initial Claims Counts & MI Central	OEEAS	This is a SUMS data warehouse application that provides information (summarized counts) on T2 Initial claims, T16 Initial claims, and concurrent tasks between the two.
SUMS Integrated Work Measurement (IWM) on MI Central	OEEAS	This is a SUMS Integrated Work Measurement MI Central application that provides the DOWR, DOWS, WUPWY, Sample Schedule and DOWS Error Reports on MI Central using WMT data.
SUMS Medicare Data Warehouse & MI Central	OEEAS	This is a SUMS data warehouse application that provides information (summarized counts) on the following Medicare workloads: Low-income subsidy, Redeterminations, Subsidy Changing Events, and Manual Corrections.
SUMS Medicare IRMAA Data Warehouse & MI Central	OEEAS	This is a SUMS data warehouse application that provides information (summarized counts) on the Medicare IRMAA workload.
SUMS Medicare IRMAA Part B Listings on MI Central	ORSIS	This is a SUMS ODS MI Central application that provides workload listings and ssn queries for the Medicare IRMAA workload. In 2011, IRMAA Part D was added. Listing labels/titles were changed to "Medicare IRMAA" instead of being Part B/Part D specific.
SUMS Medicare Part D Listings on MI Central	ORSIS	This is a SUMS ODS MI Central application that provides workload listings and ssn queries for Medicare Part D workloads: Low-income subsidy, Redeterminations, Subsidy Changing Events, and Manual Corrections.
SUMS Post-Entitlement Data Warehouse	OEEAS	This is a SUMS data warehouse application that provides information for the SDO and SDO diary reports.
SUMS RZ/LI Counts	OEEAS	This system provides RZ/LI Counts via MI Central and ad hoc queries.
SUMS SSI Processing Time & MI Central	OEEAS	This is a SUMS data warehouse application that provides processing time information on SSI initial claims.
SUMS Title II Processing Time & MI Central	OEEAS	This is a SUMS data warehouse application that provides processing time information for Title II initial claims and reconsiderations.
SUMS/MCAS Management Information (MI) Central	OEEAS	This is an Intranet application that provides SUMS/MCAS MI reports and workload listings.
Suspense Reinstate Daily Batch Adjust Reinstates	OEEAS	SRDBAR processes suspense reinstates and MEF adjustments. It creates daily output to update the MEF.
System Planning and Reporting System	OEEAS	Supports the DCS ITAB process. Allows for entry of proposals, administration of approved projects and a reporting system.

Application Information Report

Name	Owner	Description
Systematic Alien Verification for Entitlement	OSES	SAVE Web Service Process is a middleware application that will allow SSA employees to access data from the Department of Homeland Security's SAVE Web3 application through the SS-5 Assistant application developed by Office of the Deputy Commissioner for Operations (DCO) New York Regional Office (RO)
Systems Integrity Fiscal Totals	ORSIS	System Integration Totals - generates fiscal control totals for prior and current month accruals, hold checks and Medicare totals.
T16 eCOMP	OASSIS	SSI eComputations is an intranet application to assist Field Office users with manual SSI computations.
T16 Interactive Comps	OASSIS	Calculates SSI Deemed income and benefits.
T2 Alerts/Exceptions Print Process	ORSIS	PE Service & Control Offline Intercept Operations - batch Alerts printed in field offices daily.
T2R Statistics	ORSIS	Provides daily, monthly and yearly counts for processing results by type of T2R actions via the Intranet.
Target Notice Architecture	OESAE	TNA functions as a utility to format automated notices and documents, provides a repository for language/text used in TNA's automated notice processes.
TATTER Dib Cess Notices	ORSIS	Produces notices for TATTER Dib Cess actions.
TAX LEVY	ORSIS	CICS data collection for IRS Tax Levy data. Sends transactions to Title 2 for processing. Records results of T2 runs on the Data Base and pays IRS the withheld money.
Tax Levy Notices	ORSIS	Produces notices for Tax Levy System actions
Telephone Benefit Verification Letter	OSES	This application allows a beneficiary to request a proof of income letter over the 800 Number.
Telephone Knowledge based 1099	OSES	Use an 800 number to call in a request for a replacement SSA-1099 or 1042S (for non-citizens/non-residents). The replacement SSA-1099/1042 is sent by USPS within 30 days.
Telephone Knowledge Based Change of Address	OSES	Use the Telephone for your 'Knowledge Based Change of Address'
Telephone Knowledge Based Claim Status	OSES	Use an 800 number to call in to check the status of a previously submitted claim
Telephone Knowledge Based Direct Deposit	OSES	Use the internet to setup or change your 'Direct Deposit' payments
Telephone Knowledge Based Screen Splash	OSES	Screen Splash allows callers to the SSA 800 # to receive faster account-related service by entering their personal information, such as name and date of birth, using speech telephony technology before speaking with an 800 Number agent.
Telephone Knowledge Based Wage Reporting	OSES	Telephone application that uses knoweldge based authentication. User is connected to SSA over the phone via Verizon. User input is received via the phone and no user interface is involved.
Telephone Medicare Replacement Card	OSES	Allows the beneficiary to request a replacement Medicare card over the 800 Number.
Telephone Number Employee Verification	OSES	Allows users to conduct SSN verifications over the telephone. The application uses all of the same back end code as SSNVS. In addition, the application also uses a name recognition service to improve accuracy of the voice recognition used when the user speaks
Telephone Password Based Change of Address	OSES	Use the telephone for your Pin Password 'Change of Address'
Telephone Password Based Direct Deposit	OSES	Use the telephone to start or change your 'Direct Deposit' payments

Application Information Report

Name	Owner	Description
Telephone Password Check Your Benefits	OSES	Provides Title II and XVI recipients query of their account information.
Telephone PIN/PASSWORD	OSES	Allows beneficiaries to request an ACU pin and password
Terminating, Attainments, Transfers, and Terminations	ORSIS	This system builds MBR updates for DIB Cessation, Extended Period of Eligibility, Provisional Payment transactions and Expedited Reinstatements (EXR) .
Third Party Payment System	OEEAS	The Third Party Payment System (TPPS) is a register of paper checks that are known as Third Party Drafts. These drafts are issued to vendors for goods and services, to SSA employees for reimbursement of payments and to beneficiaries for Programmatic Emergency and Immediate Payments.
Third Party Query System	ORSIS	Third Party Query (TPQY) allows State, county welfare, local housing authorities, private sector landlords, medical providers and other requesting income or health maintenance offices to obtain additional benefit information from the Social Security Administration. For the most part, this involves verification of current benefits or dates of entitlement for applicants or recipients of State programs (AFDC, food stamps, etc) who may be eligible under Title II (Retirement, Survivors and Disability Insurance), Title XVI (Supplemental Security Income) or Title XVII (Health Insurance) of the Social Security Act.
Time Allocation System	OEEAS	Provides workpower data at the lowest level
Title II Account Database Update System	ORSIS	To update the Title II Online Account Data Base.
Title II Common Data Collection System (EE Common Screens)	ORSIS	This system contains the screen processor and transaction supervisors of screens which collect and update common data associated with the client or a Title 2 person.
Title II Redesign Infrastructure	ORSIS	Post-Entitlement action processing for Title 2 claimants.
Title II Redesign Notices	ORSIS	Produces notices for T2R actions
Title II SUMMARY	ORSIS	Title II processing Summary Business Function. Develops Paid versus Payable, which identifies new overpayments and underpayments. Processes Bene netting to include overpayments and underpayments Develops Household netting of overpayments and underpayments. Adjusts the MBA for Garnishment by calling the Garnishment Data base. Pays Lump Sum Death Payments when Entitlement and Eligibility determines that payment is due. Matures timely BOUDS Posts new overpayments Supplies additional interim data to Notices regarding overpayments. Processes Maturing actions i.e., Advance file award maturities and matures deferred payment dates in special payment data and processes redefferrals for Part B SMI premiums. Reacts to changes in Shadow Data that Enrollment, Entitlement and Eligibility, and Rates have applied to the Shadow record. I.E. reacts to MBA changes that are applied to Shadow history and date and RFD changes applied to shadow history determined by Entitlement and Eligibility. Builds MBC by applying all deductions to the MBA, i.e. SMI (including HSA paid payable and PINQ), Garnishment, Tax Levy and applies rounding provisions, builds rounding and SMI bit codes and BPD in
Title II Transaction History Query	ORSIS	T2 Transaction Data History

Application Information Report

Name	Owner	Description
Title II Windfall Accounting	ORSIS	Windfall offset keeps track of windfall amounts and return of that windfall to TRUST FUNDS
Title II Workload MI	ORSIS	Read the MCS IDMS database, create and store records in DB2 database. Generate all Title II Management Information.
Title XVI Database Extraction/Selection System	OASSIS	SSI database selection processes.
Title XVI Enforcement (MEF)	OASSIS	The Wage Match (IC/WM) run processes input from MEF in March and September of each year. During these months OCSE wage, unemployment, IRS 1099 and IRS Pension data are processed also. Once this data is processed, diaries are posted to the SSR. They are as follows: IRS PENSION (5H) MEF (K6 AND K7) OCSE WAGE (S2) OCSE UNEMPLOYMENT (U5) IRS 1099 (5B POSTED IN REDETERMINATION RUN)
Title XVI Summary Counts (DOWR Counts)	OASSIS	Data from Exception Control is summarized into categories and fed to the Data Warehouse to provide receipts, clearances, and pending counts data for the MI Cenral Report DOWR.
Tivoli Auto-Discovery for zOS	OTSO	TADz is a IBM COTS package which provides inventory and usage data on all Mainframe based software applications. This is used by DMRA COTRS to ensure software utilization and license compliance
TopSecret Administrator Screen Support	OTSO	Top Secret Administration Screen support
Totalization Data Exchange	OEEAS	The Totalization Data Exchange(TDEX)project is an exchange of death data between SSA and foreign totalization countries.
TR Split/Foreign Service	ORSIS	This system controls how data is split and distributed to different systems. TRSPLIT FAN CICS Traffic output. Adds a routing indicator and region to the header of the record. Valid records are split into various output files which are processed by various systems
Training Online Nomination System	OEEAS	TONS is the Social Security Administration's Training Online Nomination System. It enables the user to create and process training nominations for individual or groups of employees.
Transaction Control System	ORSIS	Control the volume and types of transactions directed to the AJS3 PE object program. Control recirculation of AJS3 transactions. Direct 4648 input to SSACCS, MCS and PE. Gather together FALCON and other CICS inputs, build finders for PE. Sweep and consolidation
Travel Manager	OEEAS	Enter travel documents - authorization, local vouchers and vouchers. Sign and approve documents electronically. Create transactions for the Financial Accounting System (FACTS) to obligate funds and reimburse the traveler for travel expenses.
Treasury Check Information System	OSES	The Treasury Check Information System (TCIS) is a replacement for the Check Payment and Reconciliation (CP&R) System. TCIS records and reconciles the worldwide issuance and payments. SSA collaborates with this system to verify payments.
TREASURY Data Exchange Service	OTSO	Payment Files to Treasury
TREASURY OPERATIONS	ORSIS	These Operations send data to TREASURY via Connect Direct in order to MAKE or WITHHOLD Payments of SSA BENEFITS.

Application Information Report

Name	Owner	Description
UniForms	ODS	UniForms (formerly Enterprise Solution eForms) will be the agency's way of accessing electronic versions of forms. This will be a user friendly application with access to forms capable of being saved, sent, fillable, signable, uploadable to the EF, and available to other applications.
Unverified Prisoner SSN	OEEAS	Identify correct identities for prisoners that are unverified by the EVS system.
Validation Planning System	OESAE	The VP System, developed by the Division of Validation and Testing Technology (DVTT), provides an automated tool for preparing validation plans (VPs). The system includes: A central database of VPs; Electronic VP approval; Capability to request actions on the VP using the integrated messaging feature; Capability to place approved VPs on the DVTT web page; Formatted print of the VP; Links to procedures on the DVTT web page; A method to collect and display comments; An audit trail of actions taken; Ability to indicate VP attachments and make them visible to other users; and Assignment of edit/release permissions by the VP author.
Verifications Account Management System	OEEAS	This is a web based intranet application that manages information about valid users of the Enumeration Verification System (EVS).
Veterans Administration	ORSIS	Reads extract file from VA compares against MBR and matches are sent back to VA
Veterans Administration System - VA PRE- EDIT	OEEAS	VA processes each monthly file from the Veterans Administration (VA) to ensure valid data is being received.
Veterans Benefit Administration Query	OEEAS	SSA field office staff have read-only access to the VA BIRLS database to verify military discharge information necessary for claims processing. The VBAQ can be found on the Data Exchange Query Menu (DXQM).
VIEWS - Agreement Workflow Tool	OEEAS	This is a web based INTRANET application that electronically controls the workflow for preparing a reimbursable agreement and routing the agreement through the various approval and sign-off steps.
VIEWS - Data Exchange Inventory	OEEAS	This application houses factual information about each of the Data Exchanges that are currently occuring in the agency with federal, state, international, and private entities.
VIEWS Central	OEEAS	This is a web site where users can obtain user guides for the Agreement Workflow Tool application and get information about VIEWS.
Visitor Intake Process	ORSIS	This is an effort to re-architect the existing Visitor Intake Process (VIP) client-server application into an enterprise level application. VIP manages appointment and walk-in traffic for the Field Offices (FO) and assigns them to the FO staff in an effective way to minimize the wait time of the users. The VIP process also includes a public interface kiosk that collects visitor information for use by the VIP database.

Application Information Report

Name	Owner	Description
Visitor Intake Process - Rewrite	ORSIS	VIPR is an intranet application that will serve over 1300+ field offices in and around the United States. This application will re- architect the existing client server application (VIP) into an enterprise level application. VIPR will assist in the management of appointments and walk-in traffic for the field offices and assign them to the FO staff in an effective way to minimize the wait time of the users. The VIPR kiosk is the public interface that collects visitor information for use by VIPR.
Visitor Intake Process Kiosk	OSES	The VIPr Kiosk application is designed to collect information directly from SSA customers visiting field offices to better manage the workflow within the field office. The VIPr Kiosk application is one of two applications in development under the umbrella of the Visitor Intake Process Rewrite VIPr project.
Vital Signs and Observations Reporting System	OESAE	VISOR is a web-based application that provides top-level Deputy Commissioner for Systems (DCS) management and others with a "quick glance" of the general "health" of projects. The key areas include scope, schedule, status, resources and risks. The application displays both, Executive Oversite (EO) and non-EO data for Development, Planning & Analysis, Maintenance, Cyclical and NCC releases.
Vocational Rehabilitation Reimbursement Management System	ORSIS	The Vocational Rehabilitation Reimbursements Management System is a case processing application supporting SSA reimbursements to State Vocational Rehabilitation Agencies (VRAs) for services the VRA provided to our recipients.
Volume Death	OEEAS	The system creates a death master file.
WC/GP Common Screens	ORSIS	This system supports common T2 data collection for Worker's Compensation/Public Disability benefits and Government Pension Benefits for processing of T2 benefits.
Web Time & Attendance	OEEAS	webTA is a web-based, Automated Time & Attendance System (ATAS) that is intended to replace the current Mainframe Time & Attendance System (MTAS).
Web-based Systematic Alien Verification for Entitlement	OSES	I-Main SAVE is a data exchange connection between the Department of Homeland Security and SSA using I-Main as the authentication tool to access the DHS SAVE application to obtain primary verification on immigration documents and determining an alien applicant's immigration status.
Websphere MI Architecture	OSES	We do not have a "front end" module in MKS for MIAR. It isn't in any way similar to a CICS application that would have had a "main menu" or other such "front end" program, the closest we could come to naming a front end to miar is the JSP that is the page for viewing the report index - that would be ReportingEngineWeb/jsp/EmisIndex.jsp Miar has more functions than just the reports, and there are JSP's and controllers for them as well.
Widows Notices	ORSIS	Produces notices for widows with possibly higher benefits due on their own account. Runs twice yearly.
Windfall Elimination Provision/Government Pension Offset	ORSIS	

Application Information Report

Name	Owner	Description
WMI for IC and Appeals	OASSIS	Legacy WMI IC and appeals batch programs and CICS screens.
Work Experience Reporting System	OEEAS	This an MI data capturing and reporting system. WERS is used to determine workload volumes and the amount of time needed to process items in each workload category.
Work Measurement Transition	OEEAS	This is a mainframe/Intranet application that collects and stores MI on work counts, work sampling and staffing hours. Specifically, WMT provides DOWR, DOWS and staffing and hour data that are accessible via standard reports on MI Central or via ad-hoc query
Workers Comp Query	ORSIS	Queries the Workman's Compensation Database and returns a query display that is supposed to look like the WC DATASHEET. Response can be returned to the screen or sent to a printer. Queries just read the WC data and displays the info. No batch processing included
Workers Compensation Redeterminations	ORSIS	Identify cases where the triennial redetermination of the Annual Current Earnings (ACE) in Workers Compensation cases should be performed.
Workload Management System for Debt Management	ORSIS	Provides totals for the online Debt Management System
Workload Management System for Post-Entitlement System	ORSIS	Provides totals for the Post-Entitlement Online System
Zip Code/District Office Code/State and County Code Tables	ORSIS	Maitains the District Office codes and State/County codes by Zipcode.
Zipcode Maintenance Operations - MBR	ORSIS	The Zip Code Management System is used to validate Zip Code data for all address changes and to perform mass Zip Code updates as required. The system uses the vendor supplied ZIP+4 software (FINALIST) provided by the Pitney Bowes Corporation to obtain a code.
Zipcode Maintenance Operations - SSR	OASSIS	Correct ZipCodes on the SSR and produce report for postal discount.

SOCIAL SECURITY

The Commissioner
July 18, 2012

The Honorable Max Baucus
Chairman, Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Thank you for your staff's May 23, 2012 email requesting additional information to complete the record for the May 17, 2012 hearing on our budget and service delivery. Enclosed you will find the answers to Senator Hatch's questions. We expect to provide Senator Coburn's answers in the near future.

I hope this information is helpful. If we may be of further assistance to you or your staff, please do not hesitate to contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

Michael J. Astrue

Enclosure

Thank you for the kind farewell remarks!

U.S. Committee on Finance, Hearing on "The Social Security Administration: Is it Meeting its Responsibilities to Save Taxpayer Dollars and Serve the Public?"

Questions for the Record
Submitted by Senator Orrin Hatch

1. **There have been several recent press reports which have raised concerns about Social Security administrative law judges (ALJs) with very high benefit approval rates when claims that have been denied at the agency level are appealed to those ALJs. In fact, Dr. Coburn and I wrote a letter about this issue to the SSA Inspector General last year.**

   Commissioner Astrue, could you describe and assess the use and effectiveness of management controls available to you regarding administrative law judges' adherence to Social Security Administration policies and procedures, along with your view of whether there are any statutory limitations that make it difficult to ensure ALJ adherence to those policies and procedures?

   Could you also provide your assessment of the effectiveness of the Social Security Administration's quality review system for ALJ decisions and whether there is any scope for improvement, either within the SSA or through legislative changes?

   One of Congress' goals in passing the Administrative Procedure Act (APA) was to protect the due process rights of the public by ensuring that impartial adjudicators conduct agency hearings. We respect that goal; however, it limits our authority over ALJs, and Federal law precludes us from using many of the traditional management tools that are applicable to the vast majority of Federal employees. Specifically, the Office of Personnel Management sets ALJs' salaries independent of agency recommendations or ratings. ALJs are exempt from performance appraisals, and they cannot receive monetary awards or periodic step increases based on performance.

   In addition, the statute restricts our authority to discipline ALJs. We may take certain measures, such as counseling or issuing a reprimand, to address ALJ underperformance or misconduct. However, we cannot take stronger measures against an ALJ, such as removal or suspension, reduction in grade or pay, or furlough for 30 days or less, unless the Merit Systems Protection Board finds that good cause exists.

   Although both the courts and the Department of Justice's Office of Legal Counsel have opined that ALJs are subject to the agency on matters of law and policy, and we emphasize that point when we train our new ALJs, the APA does not expressly state that ALJs must comply with the statute, regulations, or subregulatory policies and interpretations of law and policy articulated by their employing agencies, nor does it expressly provide that agencies have the right to discipline ALJs who fail to follow the law or agency policy when they make decisions. Congress' exemption of ALJs from performance evaluations complicates our ability to discipline ALJs who fail to follow our rules and subregulatory policies. Compliance with the law and agency policy is fundamental to ensure a fully fair and effective administrative appeals process.

Our quality review system is a vital part of the management controls we use to ensure that ALJs comply with the law and agency policy and that we have a fair and effective administrative appeals process. In structuring that quality review system, however, we have been mindful of the APA and the ALJs' qualified decisional independence. Our experience with prior quality review systems has taught us that we need to be careful so that neither our adjudicators nor the courts view our quality review system as a means to coerce ALJs into lowering or increasing their allowance rates. We can use our quality review system to evaluate if ALJs correctly apply the statute, regulations, and our interpretations of the statute and regulations when they adjudicate cases. For these reasons, our regulations provide that we may use random and selective sampling techniques to identify cases for Appeals Council review that involve any type of action (i.e., fully or partially favorable decisions, unfavorable decisions, or dismissals) and any type of benefits (i.e., benefits based on disability and benefits not based on disability). We use selective sampling to identify cases that exhibit problematic issues or fact patterns that increase the likelihood of error. However, our regulations also provide that neither our random sampling procedures nor our selective sampling procedures will identify cases based on the identity of the decision maker or the identity of the office issuing the decision.

To further our commitment to an effective quality review system, we created the Division of Quality Review (DQR) in the Office of Disability Adjudication and Review's Office of Appellate Operations in 2010. This organization reviews ALJ decisions to help us identify training needs to improve the accuracy of our decisions. DQR reviews on a pre-effectuation basis a minimum of 3,500 hearing decisions a year, which provides a statistically valid sample.

DQR has also been quite successful in implementing focused post-effectuation reviews of decisions. DQR conducts these focused reviews after the 60-day period in which a claimant has the right to appeal the ALJ decision; therefore, these focused reviews do not result in a change to the decision. However, they help us develop training programs, materials, tools, and software to support ALJs and hearing offices. These reviews focus on particular issues identified through management information, findings from other reviews, and internal and external referrals received from various sources regarding ALJ non-compliance with our regulations and policies.

These steps, along with more careful hiring and training, have substantially reduced the number of "outlier" ALJs. In fiscal year (FY) 2007, 19.6 percent of the ALJ's allowed 85 percent or more of their cases; that figure so far for FY 2012 is 5.1 percent. During those timeframes, about 1 percent of ALJs allowed 20 percent or less of their cases.

2. **Certain individuals and entities are excluded from participation in Medicare and State Health Care Programs under some anti-fraud provisions of the Social Security Act's Section 1128 if, for example, they have committed fraud or have had their practitioner's license revoked or suspended. However, as I understand it, those provisions apply only to a particular definition of "federal health care programs," and Social Security's DI and SSI programs are not considered to be federal health care programs under the Social Security Act.**

   Commissioner Astrue, could you tell me what safeguards SSA has in place to ensure that a medical consultant for SSA who participates in the process of making a disability determination has not been previously excluded from participation in federal health care programs as defined in the Social Security Act?

   Prior to hiring medical and psychiatric consultants, we review the Department of Health and Human Services, Office of the Inspector General's List of Excluded Individuals and Entities to verify credentials and licensure status and to identify any sanctions against the consultants. We continue to verify this information each year for our medical and psychiatric consultants. If they are sanctioned, we do not hire or contract with them.

3. **As I understand it, the Debt Collection Improvement Act of 1996 established policies to move non-tax federal payment to electronic means. The Treasury department has generally moved to implement requirements for receipt of electronic payments and is supposed to ensure that payment recipients receive funds at a reasonable cost and with consumer protections by encouraging direct deposit. Treasury has recently proposed a rule which says that new recipients of federal payments as of May 1, 2011 and current recipients as of March 1, 2013 would be required to receive payments either by direct deposit or by use of a Direct Express debit card.**

   Commissioner Astrue, could you explain requirements for electronic receipt of benefits that currently apply or will apply to beneficiaries of the Social Security system?

   The Department of the Treasury's (Treasury) regulation (31 CFR Part 208) requires all new recipients of Federal benefit payments to receive their payments electronically effective May 1, 2011. In addition, current beneficiaries who receive their payments by check must change to electronic payment as of March 1, 2013. These provisions apply to both Social Security and Supplemental Security Income beneficiaries. Treasury may waive this requirement in certain cases.

   Could you explain any exemptions as well as processes in place for allowing benefit recipients to apply for an exemption?

   Treasury will automatically grant a waiver to beneficiaries receiving payments by check who are over age 90. Treasury will also exempt individuals whose Direct Express card has been suspended or cancelled.

Treasury may grant a waiver when a beneficiary has requested one based on his or her inability to manage an account at a financial institution or a Direct Express card account due to a mental impairment or because he or she lives in a remote geographic area that does not have the infrastructure necessary to handle electronic financial transactions.

We defer to Treasury for specific information regarding the waiver process.

Could you explain whether recipients of benefits from the Social Security system will be subjected to transactions fees upon use of any electronic payment media used or to be used by the Social Security system in making payments?

There is no sign-up fee and no monthly account fee to use Treasury's Direct Express card. Many other services are also provided free of charge.

While most services are free, Direct Express will charge customers a fee for some services. Please see this link for more details: http://www.usdirectexpress.com/edcfdtclient/docs/faq.html#17.

Could you explain whether it is your assessment that some benefit recipients may find it confusing or difficult to use electronic value storage media within which they may be receiving or may be required to receive benefits from the Social Security system?

While we defer to Treasury with respect to information about specific efforts to mitigate any confusion related to mandatory electronic payment, we actively support Treasury's efforts to educate the public about the safety, ease, and convenience of electronic payments. We believe that our joint communication efforts will go a long way towards mitigating any confusion related to the new rule.

Treasury provides information about electronic payments on its website: http://godirect.org. In addition, we have a page on our website that addresses issues related to mandatory electronic payment: http://www.socialsecurity.gov/deposit/.

Could you explain what will happen on March 1, 2013 if a deadline arrives requiring electronic payment receipt for benefit recipients who currently receive paper checks but have not signed up for either direct deposit or a Direct Express debit card? Would those beneficiaries be sent a debit card anyway and, if so, how can you ensure that they will be able to access their benefits?

We support Treasury's goal to avoid interruption to benefit payments. We defer to Treasury with respect to their plans for ensuring that payment continues without interruption.

SOCIAL SECURITY

The Commissioner

December 5, 2012

The Honorable Sam Johnson
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your July 17, 2012 letter requesting additional information to complete the record for the hearing on the disability appeals process. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

Michael J. Astrue

Enclosure

Questions for the Record
For the June 27, 2012 Hearing
On the Disability Appeals Process

Questions from Chairman Johnson

1. **If medical evidence is sufficiently developed prior to the hearing, are there other reasons to leave the record open?**

   The main reason to leave the record open is to allow an administrative law judge (ALJ) to consider, without requiring a new application, a new condition (e.g., the individual suffers a heart attack the day after the hearing but before the decision is issued) or undiagnosed conditions existing at the time of the determination or decision (e.g., the claimant had been diagnosed with Hepatitis C at the time of the hearing but a month later is diagnosed with Stage 4 liver cancer).

2. **What are the pros and cons of closing the record either just before the hearing or at the close of the hearing before an Administrative Law Judge (ALJ) issues a decision?**

   A closed record would provide the ALJ with all the necessary information to fully consider the claim prior to the hearing, and the ALJ would have the necessary information to adequately question the claimant or witnesses at the hearing. Furthermore, a significant number of ALJ decisions are remanded because new and material evidence (i.e., relevant to the time adjudicated by the ALJ, not previously considered, and may change the outcome) available at the time of the ALJ decision is submitted after the ALJ issues a decision. Some have argued that closing the record at the time of the ALJ's decision would encourage claimants to develop and present such evidence in time for the hearing (where possible), leading to a timelier and lower-cost resolution of the claim.

   As previously stated, the main reason to leave the record open at the hearing level is procedural. Should a claimant's condition worsen or a new condition arise, there are fewer administrative steps if the ALJ record remains open. For example, the claimant would not have to file a new application if a new condition arose the day after the hearing but before the decision was issued, assuming the ALJ became aware of the condition.
   The same protections afforded under the current process can be incorporated into a closed record provision, like the provision our Boston Region hearing offices use. In the Boston Region (as noted in 20 CFR 405.331), absent certain criteria, evidence must be submitted no later than five business days before the date of the scheduled hearing. However, to protect claimants, the rules do allow for the acceptance of evidence after this time period if our action misled the claimant, the person had a limitation that prevented submission of the evidence earlier, or some other unusual, unexpected, or unavoidable circumstance beyond the claimant's control prevented submission of the evidence. This provision encourages the timely submission of evidence while still allowing for the late receipt of evidence in appropriate circumstances. We are continuing to evaluate use of these procedures in the Boston Region.

3. **The expectation for judges to produce between 500-700 cases per year has been in place since October 31, 2007. Ex 6 believes this focus on "numerical quotas" does not provide sufficient time for the ALJ to do the proper job and issue a correct decision. Do you believe that this is still the right expectation?**

   The following chart shows the percentage of ALJs (excluding newly-hired ALJs) meeting our 500 to 700 case expectation since fiscal year (FY) 2007:

Percent of Tracked ALJs Disposing of 500 or More Cases	
2007	46
2008	56
2009	71
2010	74
2011	77

   The vast majority of ALJs are meeting this expectation. Since 77 percent of ALJs met this expectation in FY 2011, while maintaining a high level of decisional quality, we believe the expectation is reasonable.

   Moreover, in a recent survey conducted by the Association of Administrative Law Judges, nearly three out of four respondents found it "not difficult at all" or only "somewhat difficult" to meet the expectation. When given an opportunity to explain why they had not met our expectation, many respondents cited their status as new ALJs. We do take into account the learning curve for new ALJs. We reiterate the importance of making the right decision; consequently, we excluded newly-hired ALJs from the data shown above.

4. **What percent of judges are meeting this expectation and what will it take to get the remaining judges to meet this expectation?**

   In FY 2011, 77 percent of ALJs achieved the expectation of 500 to 700 dispositions per year. We have initiated a number of measures to help ALJs achieve this goal and to identify any impediments to achieving this goal. To that end, we regularly monitor whether ALJs are on pace to achieve the dispositional goal. When ALJs are not on pace, we discuss it with them to determine the root cause of the problem. When appropriate, we offer assistance in the form of docket management, mentorship, policy training, and technology-related support.

   We have also developed an online tool, "How MI Doing," which provides ALJs with current real-time statistical information about their individual productivity and quality of their decisions. Accordingly, ALJs are now able to track their performance and take self-corrective measures when necessary. Additionally, we are developing another automated tool, the electronic bench book (eBB), which we believe will help ALJs increase their efficiency and productivity.

5. **What new authorities, if any, do you need to address ALJ conduct and performance issues?**

   We constantly strive to improve our ALJ hearings and are guided by the principles that they must be fair, accurate, and efficient. We are continuing to evaluate if any statutory measures would enable us to better to meet these goals.

6. **According to an April 2012 Inspector General Audit Report, "The Role of National Hearing Centers in Reducing the Hearing Backlog," ALJs in the National Hearing Centers had a disposition rate 15 percent higher than the average national disposition rate with 2.77 cases per hearing center ALJ compared to 2.42 cases per hearing office ALJ. The Inspector General attributed some of this increase to productivity, at least in part, to the supervisory relationship between the ALJs and the attorney writers. Would this be a good model for all hearing offices?**

   We agree that the model for our National Hearing Center (NHC) offices is conducive to productivity and certainly has some advantages. We are continuing to study which aspects of NHC model warrant expansion to our broader hearing offices.

7. **A recent Social Security Inspector General (IG) report, "Current and Expanded Use of Video Hearings," requested by the Appropriations Committee, noted that video hearings helped to reduce backlogs, improve case processing times, and decrease ALJ travel to remote sites, generating savings ranging from $52 to $109 million over a ten-year period. The ALJs at the National Hearing Centers use video hearings exclusively. Do you plan to expand their use?**

   Yes. So far this fiscal year, we have installed an additional 108 video units, bringing our national total to 1,339. We plan to install an additional 76 units by the end of the calendar year.

8. **You were asked several questions about your decision not to reveal the presiding ALJ's identity until the day of the hearing. In a recent report, the IG reported that claimants or their representatives were declining video hearings so that their case would be assigned to a judge with a higher award rate. To prevent this, the IG recommended that the agency establish regulations to prevent claimants and their representatives from declining a video hearing close to the day of the hearing and to remove the ALJ's name from hearing notices as well as not revealing the ALJ's name when asked by the representative. The Senate Fiscal Year 2013 Labor-HHS Appropriation bill includes language supporting your actions, saying that efforts by claimants or their representatives to manipulate the hearing process to find favorable judges challenges the integrity of the process.**

   a. **Tell us more about the abuses you were trying to correct in deciding not to reveal the ALJ's name until the day of the hearing and how the process is working.**

We prefer not to identify specific abuses because we do not want to give a road map. In general terms, the decision to remove the names of ALJs from pre-hearing notices limits the potential for forum shopping, prevents decisional delays, helps maintain the integrity of our decision-making, and is a part of our ongoing effort to ensure that all claimants (including those who are not represented and are less likely to be aware of ALJ rates) receive a fair, consistent, and timely disability hearing. This process has only been in place for a few months, but we are not aware of any new instances of forum shopping similar to what we had discovered. Therefore, the process seems to be helping.

However, given the disquiet about this process, we hope that removing ALJ's names from the notice is a temporary fix and that the representative community will work with us to ensure the integrity of our system. Since the hearing, I have had very positive interactions with both the National Organization of Social Security Claimants' Representatives and the National Association of Disability Representatives about options to address forum shopping.

b. The IG's report focuses on video hearings. Could you have instituted your "Judge Anonymous" policy only for video hearings and not for in person hearings?

While the IG's report focused on video hearings, forum shopping is not limited to those hearings. Under the current regulatory authority that was in effect at the time the "Judge Anonymous" policy was implemented, claimants are assigned the first available slot for a hearing, which may be in person or by video teleconference. We schedule the hearing and notify the claimant and his or her representative of the time and place of hearing. If a claimant is scheduled for a video hearing, then he or she can decline to appear by video when he or she acknowledges receipt of the notice of hearing. Because we cannot determine under the existing system who will and will not decline a video hearing prior to scheduling a hearing, we could not have instituted the "Judge Anonymous" policy for only video hearings and not for in-person hearings

9. What changes have you made to help the Appeals Council reduce its backlogs and how often does the Appeals Council use own motion review to consider ALJ decisions?

The Appeals Council backlog has grown primarily because of the unprecedented number of requests for review filed in the past four years. In FY 2011, the Appeals Council received 173,332 requests for review, an increase of nearly 35 percent from FY 2010 (128,703 requests for review). Through June 2012, the Appeals Council received 128,750 requests for review, an increase of 15.5 percent from the same time period in FY 2011. The Appeals Council issued 126,992 dispositions in FY 2011 and 119,545 in FY 2012, through June.

In recent years, the Appeals Council has made great strides in systems automation and capturing data on case adjudication. The Appeals Council developed, and is now using, the Appeals Review Processing System (ARPS), an Intranet case processing system. ARPS helps staff identify errors, prepare recommendations for review, identify trends, and provide

feedback to adjudicators and staff. This process allows us to decide cases more quickly and accurately.

In addition to the data collected in ARPS, Appeals Council management developed numeric productivity standards for analysts who review and prepare recommendations for the Appeals Council. The Appeals Council tracks staff performance and provides additional training in areas where analysts do not meet productivity standards.

In the last few years, the Appeals Council developed an interactive training model that received the prestigious W. Edwards Deming Training Award from the Graduate School USA in 2011.

The Appeals Council is creating a new case assignment model that will group cases with similar issues and assign those cases concurrently. This change will improve consistency and help identify areas for future training, while also decreasing processing times for all claimants.

Regarding own motion reviews, the Appeals Council reviews fully favorable cases and bureau protests (i.e., cases that our employees bring to the Appeals Council's attention because they cannot effectuate the ALJ decision). The Appeals Council exercised own motion review on 812 fully favorable cases (22 percent of cases reviewed) and 326 bureau protests (55 percent of cases referred) in FY 2011. Through June FY 2012, the Appeals Council exercised own motion review on 1,449 cases (26 percent of cases reviewed) and 156 bureau protests (44 percent of cases referred).

10. Do all decision makers, whether at the State Disability Determination Services, or the hearing level, or the Appeals Council, use the same criteria for deciding claims? If not, how can we correct this problem?

Yes. The Act and our regulations set forth the criteria all decision makers must use. We have developed tools at the disability determination services (DDS) and hearing levels to ensure that adjudicators follow our policies consistently.

At the DDS level, we have the Electronic Claims Analysis Tool (eCAT), which will be mandatory as of October 1, 2012. 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. eCAT utilizes "intelligent pathing" and quality checks to assist the user in addressing critical policy issues relevant to the claim. The output from eCAT is the "Disability Determination Explanation (DDE)," which is a detailed record of the documentation and analysis supporting the determination. The DDE is uploaded to the electronic folder so it is available for subsequent reviewers.

At the hearing level, we are working on a pilot of the eBB for hearing level adjudicators later this year. The eBB is a web-based tool that aids in documenting, analyzing, and adjudicating a disability case according to our regulations. Wherever possible, we reuse data to limit the

need to re-enter information. eCAT and eBB are designed to pull in and display information entered from various sources. We designed these electronic tools to improve accuracy and consistency in the disability evaluation process. Additionally, our tool "How MI Doing?" gives adjudicators extensive information about the reasons their cases were subsequently remanded and allows them to view their performance in relation to the average of other ALJs in the office, region, and Nation. Currently, we are developing training modules for each of the 170 bases for remands that eventually will be linked to this tool.

11. The new partnership between the Social Security Administration and Kaiser Permanente will electronically transmit complete medical records of Kaiser Permanente patients to the agency with appropriate consent. What are your views on the impacts health information technology will have on the disability process?

Health IT has enormous potential. Providers and our agency spend considerable time trying to track down, copy, and mail medical records. The use of Health IT will dramatically improve the speed, accuracy, and efficiency of this process, reducing the expense of making a disability decision for both the medical community and taxpayers while improving service to the public.

On an annual basis, we send more than 15 million requests for medical records to healthcare providers—and we count on those providers to take time from their busy practices to respond. This mostly paper-based, manual workload is a time-consuming part of the disability process. By fully automating the process for requesting and obtaining electronic medical records, we can receive medical records within a matter of minutes as opposed to days, weeks, or months.
In addition, electronic records lend themselves to computerized analysis, which alerts disability examiners of an impairment that may meet our medical criteria. We look forward to the standardization of electronic records because that will give us other opportunities to provide decisional support for examiners. It will also help us collect data that may influence our policies and training.

Unfortunately, we must wait for Health IT to become the standard before we can truly realize its potential. In FY 2012 (through July), only about 16,500, or .11 percent, of our 15 million requests for medical evidence utilized Health IT. We now can quickly obtain electronic medical records from 14 organizations, which continue to expand their use of Health IT and add facilities. We estimate receiving an additional 10 percent of electronic medical records each year. We are excited that Kaiser Permanente has agreed to help us move this needle.

Currently, the average time for initial disability decisions is 21 percent lower in cases with electronic medical evidence obtained through Health IT. In fact, we decided 3 percent of those cases within 48 hours.

12. Social Security's policy clearly states that the substantial gainful activity earnings criteria is not applied to applicants who are in the military and who continue to receive active duty pay. I have heard that despite the agency's efforts to educate staff about this policy, members of the military are sometimes still denied disability benefits on the basis of earnings. Please describe the efforts you have taken to date to educate the field office staff, State Disability Determination Services, and ALJs regarding this policy. Given that the policy is still being incorrectly applied, what steps do you plan to take?

We apply the substantial gainful activity (SGA) criteria to all disability cases, including military cases. When evaluating for SGA, we take into consideration that a member of the military may continue to receive active duty pay but may not be able to perform job duties. We remind our staff that it is not appropriate to evaluate SGA under the earnings guidelines alone. Instead, we use additional criteria to evaluate the level and type of work activity performed by a service member receiving treatment, working in a designated therapy program, or on limited duty. We regret that our employees sometimes fail to correctly apply our policy.

The following policy guidance materials educate our field offices, State DDSs, and our hearing offices regarding this issue:

- "Evaluating Military Wages in the Trial Work Period (TWP)." This policy reminder includes guidance on properly evaluating earnings and determining TWP months when a claimant is receiving Title II benefits and military pay.

- "Evaluating Internships in Wounded Warrior Cases to Determine TWP." This policy reminder includes instructions for correctly applying TWP service months and reminders on evaluating work activity for military service personnel who continue to receive full pay while recuperating from injuries.

- "Interim Processing Instructions for Incentive Therapy and Compensated Work Therapy (CWT) Programs for Title II Benefits," which clarifies the exclusion of income received while veterans are participating in these programs from the definition of wages and provides guidelines for evaluating CWT and Incentive Therapy program income for SGA and TWP.

- "Processing Wounded Warrior claims." These reminders covered a wide range of policy areas, including information addressing military pay and SGA.

- "Evaluating Military Pay." This training video focuses on SGA and TWP determinations for military personnel who may still be receiving full military pay. We also produced a second training video to provide Military Service Casualty/Wounded Warrior case interviewing and claims handling reminders to our field office employees. The video specifically addresses developing SGA.

We also developed a checklist for use in wounded warrior disability claims. The checklist includes reminders to fully develop and evaluate work activity since military personnel may continue to receive active duty pay although their job duties have changed.

We have an expedited policy that applies to military service members claiming disability that occurred on or after October 1, 2001 while on active duty status. We flag these cases as having military casualty or wounded warrior case involvement. This flag assures priority status. We have developed training materials to explain this policy.

Enclosures

SOCIAL SECURITY

The Commissioner

December 5, 2012

The Honorable Xavier Becerra
Ranking Member, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Becerra:

Thank you for your July 16, 2012 letter requesting additional information to complete the record for the hearing on the disability appeals process. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

Michael J. Astrue

Enclosures

Questions for the Record
For the June 27, 2012 Hearing
On the Disability Appeals Process

Questions from Representative Becerra

1. **Does SSA use objective diagnostic criteria in determining whether non-exertional impairments or limitations are of such severity that the individual meets the eligibility criteria to receive disability benefits? Please discuss.**

   Yes we do. Allegations of pain or other non-exertional (i.e., non-strength related) impairments or limitations are not sufficient for us to award disability benefits. We require objective medical evidence and laboratory findings that show: 1) a claimant has a medical impairment that could reasonably be expected to produce the pain or other symptoms alleged, and 2) when considered with all of the other evidence, meets our disability requirements.

2. **How extensive is the variability in allowance and denial rates between Administrative Law Judges (ALJs) - that is, do the majority of judges cluster within a middle range, or are they widely distributed? Might there be legitimate circumstances where an ALJ could have allowance rates that are higher or lower than the average? What steps is SSA taking to address concerns that some judges may not be properly following SSA's criteria and procedures for weighing evidence and making determinations?**

   The majority of ALJs cluster within a narrow range of the mean, with a reduction in the significant outliers in the last few years. Some variance is expected in decision-making because of the variation expected in the random allocation of claims each judge reviews and judicial independence required to adjudicate a claim. Our main concern with outliers is whether their decisions are policy compliant and accurate.

   To ensure adjudicators issue policy compliant decisions, we continue to improve training programs and create better individual feedback tools, such as "How MI Doing?" This resource gives adjudicators information about their remands, including the reasons for remand, as well as information on their performance in relation to other ALJs in their office, their region, and the Nation. Currently, we are developing training modules related to each of the 170 identified reasons for remand that we will link to the "How MI Doing?" tool. Further efforts to promote policy compliance include a test pilot of the Electronic Bench Book (eBB) later this year. The eBB is a policy compliance web-based tool that aids in documenting, analyzing, and adjudicating a disability case in accordance with our regulations to improve decisional accuracy and consistency.

   Our Office of Appellate Operations created the Division of Quality (DQ) to perform focused, post-effectuation reviews of hearing offices, ALJs, representatives, doctors, and other subjects. We identify potential subjects for focused reviews from data collected through our systems, findings from pre-effectuation reviews, and internal and external referrals received from various sources regarding potential non-compliance with our regulations and policies. Focused reviews allow us to examine how ALJs and hearing offices adjudicate cases, and, if

necessary, help develop training programs, materials, tools, and software to support ALJs and hearing offices. A focused review also allows us to provide feedback regarding our findings.

3. **What fraction of all allowances are made at each decisional level - DDS, reconsideration, ALJ, Appeals Council, and federal court? Are ALJs responsible for the recent growth in the number of disability beneficiaries? What are the reasons that an ALJ would allow benefits that have been denied previously by the DDS?**

The longitudinal data for claimants who filed claims in a given year provides the most accurate information on the percentage of total allowances at each level. It can take several years for a cohort of claimants to move through the appeals process; therefore, the most recent cohort for which we have the most complete data are claimants who applied for disability benefits in 2007. We tracked those claims through October 2011, and the breakdown of allowances is:

- Initial level (DDS): 69.4 percent of all allowances
- Reconsideration: 5.6 percent of all allowances
- Hearing level (ALJ): 24.9 percent of all allowances
- Appeals Council and Federal Court levels: 0.1 percent of all allowances

Our ALJs are not responsible for the growth in the number of beneficiaries. Allowance rates have dropped at the initial and ALJ levels. The growth in beneficiaries is not surprising as the Baby Boom generation enters its most disability prone years and the increase in women working has increased the size of the workforce that may be eligible for benefits.

There are several reasons why ALJs allow previously denied claims. For example, claimants' conditions worsen over time; claimants may submit new medical evidence at the hearing level that was not previously available; they may hire an attorney or non-attorney to represent them; and a claimant's age at the time of the decision may require different evaluation criteria. In addition, hearing cases involve complex issues with conflicting evidence.

4. **What is SSA's view on the question of whether the ALJ process is constitutional?**

It is constitutional.

5. **What is your perspective on some of the proposals made by Professor Pierce in his testimony - such as revising the ALJ discipline process, eliminating non-exertional impairments as a basis for qualifying for benefits, and eliminating appeals before an ALJ? Would these require statutory changes?**

Changes regarding any of these complex issues would require Congressional action. Some relevant citations include 5 U.S.C. § 7521, 42 U.S.C. § 423(d), and 42 U.S.C. § 405(b).

6. **How many requests for review does the Appeals Council receive each year? What is the average length of time to log a request for review into the system, and once logged, to make a determination on that request for review? What safeguards are in place to ensure that all requests for review are indeed logged and processed? Given that all other administrative appeals must now be filed electronically, have electronic requests for review been considered?**

   In recent years, the Appeals Council has experienced a substantial increase in requests for review. In FY 2011, the Appeals Council received 173,332 requests for review, nearly 35 percent more than the 128,703 requests received in FY 2010. Through June 2012, the Appeals Council received 128,750 requests for review, an increase of 15.5 percent over the same time period in FY 2011.

   Despite this significant increase in the Appeals Council's workload, the average processing time (APT) at the Appeals Council increased only 15 days from 345 days in FY 2010 to 360 days in FY 2011 and another 18 days to 378 days through June FY 2012 because we focused on adjudicating our most aged, complex cases first, which increases the APT.

   We recently improved our business process to ensure that once we receive a request for review it is logged into our system within five business days. We agree that electronic requests for Appeals Council review would be beneficial; however, we must prioritize our limited resources, and we have many other higher priority initiatives that will help us better fulfill our responsibilities to serve the public.

7. **What is the average length of time that a case spends at the Appeals Council? In responding to these questions, please provide yearly data for the prior 10 years to date. What is the longest a case has spent at the Appeals Council? Are there any goals or processes in place to reduce the length of time for Appeals Council proceedings? Once a case is at the Appeals Council, how long has that claimant typically been in the application and appeals process?**

   Below is a chart with the APT for Appeals Council decisions for the last ten fiscal years.

Fiscal Year	APT
2002	412
2003	294
2004	251
2005	242
2006	203
2007	227
2008	238
2009	261
2010	345
2011	360
2012 (though 6/29/12)	378

Currently, the oldest request for review pending before the Appeals Council is from October 18, 2007. Although our business process does not support electronic filing of requests for review, we accepted this request for review using the process for accepting evidence electronically, which misfiled the request in the closed hearing folder. Once we realized that this type of misfiling could happen, we developed a computer program to search for such lost requests and found this one. We discovered this particular case on November 2, 2012, and we are expediting the case. Of the more than 160,000 requests for review currently pending, we have only 30 pending requests for review dated prior to 2010.

We have implemented changes in our business processes, systems, and training, and as noted above, we are continuing to evaluate other ways to improve our processes. For example, we are currently developing clustering analysis technologies to identify cases that involve similar issues. Assigning cases with similar issues concurrently will help improve training and consistency while providing quicker decisions for all claimants. In FY 2012, our goal is to handle 80 percent of the cases pending over 365 days and 99 percent of the cases pending more than 545 days. We are currently on pace to achieve these goals.

At each level of adjudication, the processing time ends when we make a decision; therefore, we do not currently capture the information on the average time between initial application and an appeal to the Appeals Council.

8. **What percentage of requests for review are granted by the Appeals Council and what percentage of requests for review are denied? What percentage of reviewed cases are affirmed? What percentage of reviewed cases are overturned or remanded? In the event a case is overturned or remanded, what are the most common reasons that the Appeals Council makes that decision?**

The enclosed chart provides the requested information.

The Appeals Council captures data on approximately 170 reasons for remand, but the most common reasons for Appeals Council remands are: improper evaluation of treating source opinions; inadequate evaluation of exertional and mental limitations; failure to discuss the required factors when assessing credibility; improper dismissal of a hearing request; inadequate consideration of mental impairments; and new evidence presented at the Appeals Council.

The most common reasons for Appeal Council reversals relate to improper evaluation of the listings and misapplication of the Medical-Vocational Guidelines.

9. What percentage of denials of review result in a civil action? Are there any estimates regarding the change in number of civil actions filed (increase or decrease) if the Appeals Council were eliminated? Is there any evidence regarding the cost of an Appeals Council denial versus a civil action?

As the data below indicate, the percentage of Appeals Council denials resulting in a civil action has decreased in recent years.

Fiscal Year	Number of denials issued	Number appealed to Federal court	Percentage of denials appealed
2002	81,208	16,431	20.2
2003	71,053	18,191	25.6
2004	68,216	15,053	22.1
2005	66,596	14,455	21.7
2006	66,159	13,006	19.7
2007	59,511	11,868	19.9
2008	59,781	12,257	20.5
2009	63,891	12,167	19.0
2010	73,879	12,420	16.8
2011	92,145	13,955	15.1
2012 (thru March 30, 2012)	55,892	7,648	13.7

The data above suggest that eliminating the Appeals Council would negatively affect Federal courts. Some of the cases that the Appeals Council remands or reverses (i.e., issues a favorable decision) would be directly appealed to Federal District Court. In FY 2011, the Appeals Council remanded 26,909 cases and reversed 3,122 cases. In the absence of an Appeals Council review, we estimate that Federal District Courts could receive at least 15,000 more cases a year, which would more than double Federal District Court case filings.

Eliminating the Appeals Council would also negatively affect claimants. The Appeals Council protects the integrity of a national disability program, thus ensuring consistent treatment for claimants residing in different areas of the country. Further, the Appeals Council's oversight of the ALJ hearing process provides an appellate review for all claimants, without the cost of court filing fees. In FY 2011, the Appeals Council review provided a more favorable administrative action (remand or favorable decision) for claimants in over 30,000 cases.

The Appeals Council has several other crucial roles. It is the only administrative body that can reverse, reopen, or revise hearing-level decisions on behalf of the Commissioner. Appeals Council review not only ensures that ALJs apply appropriate policies, but also provides structured data to evaluate agency disability processes and policies. The Appeals Council also performs focused reviews of hearing-level decisions to ensure policy compliance and identify possible ALJ training needs. Appeals Council feedback and review has resulted in several policy and procedural changes, thereby saving resources and improving our disability process.

In FY 2011, the average cost of an Appeals Council review was $1,405. We do not know all costs involved with a civil action in Federal court.

10. Statistics from 2011 kept by the National Organization of Social Security Claimants Representatives show that 49% of appeals to federal court result in a remand for either payment of benefits or a new hearing. Given this statistic, are there any goals or processes in place to improve the quality of Appeals Council review and reduce the number of cases filed in federal court?

We have seen a decline in the percentage of cases remanded to the Appeals Council from Federal District Courts. In FY 2004, the remand rate was nearly 63 percent. By contrast, the remand rates for FY 2011 and the first half of FY 2012 were 42 percent and 39 percent, respectively. We continue to work in a variety of areas to maintain this trend by ensuring that our decisions are factually accurate and procedurally adequate and that the courts understand the rules we follow.

For example, last year we assigned administrative appeal judges to the Division of Civil Actions to analyze court remands and requests for voluntary remands, provide feedback, and conduct trend analyses. Additionally, we reinstituted the quality assurance sample review conducted by the Appeals Council so that we can offer training to improve quality and reduce the number of court cases remanded from district courts.

For several years, we have collected data on the reasons for remand from the Appeals Council and Federal District Courts. With innovative techniques that arrange data in heat map formats, we can identify variances and areas of concern. Heat maps for FY 2010 and FY 2011 show inconsistencies among the Federal District Courts regarding the percentage of cases remanded, showing the need to further evaluate how certain courts apply our policies. These maps suggest trends in the reasons for remand. In Federal District Courts, the top two reasons for remand are: 1) evaluation of the claimant's credibility;
and 2) treating physician opinions. These reasons also rank high among remands from the Appeals Council.

To address the evaluation of credibility issue, we formed a workgroup to revise decisional language addressing credibility and the decisional templates that ALJs and decision writers use to evaluate credibility. We anticipate these revisions will be available early in 2013.

We are also considering how Federal Courts' interpretations of our treating physician policy affect remands. The courts have influenced our rules in this area. While courts generally agreed that adjudicators should give special weight to treating source opinions, they have formulated differing rules about how adjudicators should evaluate treating source opinions. In 1991, we issued regulations that articulate how we evaluate treating source opinions. However, the courts have continued to interpret this rule in conflicting ways.

The Administrative Conference of the United States (ACUS) is currently studying the treating physician rules. We have asked ACUS to analyze the effect of these rules on Federal Courts' reviews of disability decisions and consider measures that we could take to reduce

the number of cases remanded to the Appeals Council. We have also requested that ACUS study the role of the Appeals Council in reviewing cases to reduce any observed variances in adjudication. This study will consider issues such as expanding the Appeals Council's existing authority to conduct reviews of ALJ decisions. We will be happy to work with the Subcommittee on this issue.

While we wait for the report from ACUS, the Appeals Council is evaluating the consistency of its actions and performing quality assurance reviews. Using these initiatives, we will be able to offer training to improve quality and reduce the number of cases remanded from district courts.

11. What is the annual cost of the Appeals Council stage of the Social Security claims process? What fraction does this represent of the entire amount spent by SSA on adjudicating disability claims?

For FY 2011, Appeals Council costs were $178 million. This amount represents 3 percent of the total amount spent on our disability process.

Despite having a relatively small percentage of the agency workforce, the Appeals Council handles critical functions in addressing the most complex cases pending with the agency and performing a variety of other responsibilities to assure quality. Many of the cases pending at the Appeals Council involve very difficult and complex issues that were unable to be resolved at a lower level of adjudication. Especially in regards to cases involving non-disability issues, the Appeals Council frequently encounters issues that are novel and require extensive research. Notwithstanding the complexity of these issues, however, the Appeals Council is on pace to meet the FY 2012 processing goal of clearing 80 percent of the cases pending over 365 days, and 99 percent of the cases pending over 545 days. Due to significant improvements in the process, the Appeals Council has continued to increase the number of dispositions.

For many years, the Appeals Council was not adequately staffed or funded to perform its oversight responsibilities, and there were significant efforts to eliminate the Appeals Council altogether. Recently, with additional staffing, the Appeals Council was able to implement quality assurance initiatives and improve judicial training, both of which have had a substantial positive impact on the agency. By utilizing more of its oversight role, the Appeals Council has been instrumental in driving a dramatic decline in programmatic errors, unexpected outcomes, and the allowance rate, resulting in substantial costs savings and a decrease in overpayments to claimants.

Enclosure

Enclosure for Question 8

APPEALS COUNCIL GRANT REVIEW RATES 1999-2012									
Fiscal Year	Receipts	Pending	Dispositions						Grant Review Rates*
			Total	Deny	Remand	Dismissal	Reversal	Affirm	
1999	115,150	144,525	91,173	66,100	20,135	2,794	1,824	320	24.44%
2000	106,358	127,687	125,235	93,746	26,012	3,257	1,923	297	22.54%
2001	78,833	95,355	110,666	80,235	25,417	2,720	2,064	230	25.04%
2002	83,063	59,781	115,467	81,208	27,636	3,066	2,619	938	27.01%
2003	92,047	51,078	100,750	71,053	24,801	2,526	2,164	206	26.97%
2004	92,540	45,911	97,701	68,216	24,811	2,362	2,072	240	27.76%
2005	89,430	41,258	94,083	66,596	22,739	2,357	2,173	218	26.71%
2006	94,755	44,032	93,538	66,159	23,083	2,117	2,009	170	27.01%
2007	96,260	53,163	87,129	59,511	23,121	2,131	2,070	296	29.25%
2008	93,423	62,210	83,407	59,781	18,765	2,365	2,001	495	25.49%
2009	106,965	80,040	89,066	63,891	19,700	2,840	2,094	541	25.08%
2010	128,703	106,664	102,062	73,879	22,215	2,726	2,591	651	24.94%
2011	173,332	153,004	126,992	92,145	26,909	3,828	3,122	988	24.43%
2012**	128,750	159,924	119,545	89,917	22,099	4,588	2,170	771	20.95%

*The grant review rate includes the remands, reversals, and affirmations divided by the total number of dispositions (including dismissals)

** Through June 29, 2012