

**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.