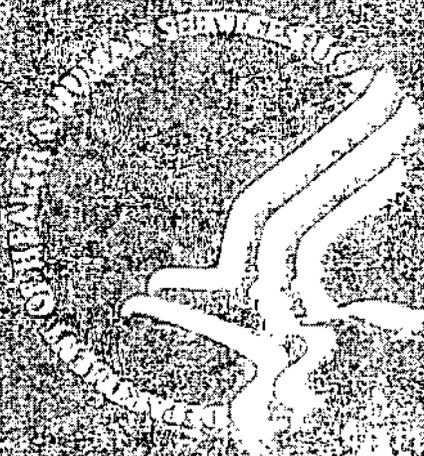


PLAN FOR A  
NEW DISABILITY CLAIM PROCESS



Social Security Administration

September 1994

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# MESSAGE FROM THE COMMISSIONER

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## **Social Security Administration's Plan for a New Disability Claim Process**

It was 10 months ago that I challenged this Agency to restore public confidence in its programs, provide world-class service to its customers, and ensure a nurturing environment for its employees. While there is much left to be done to meet these goals, I am proud to say that with the release of this document we have reached a major milestone toward meeting the challenges I set forth.

This document lays the foundation for the new disability claim process. It is a solid foundation upon which to build--it provides a broad description of the new process, with the detailed elements of the process to be developed.

The new design gives us the opportunity to develop relationships with the public and our employees that are based on open communication, partnership, and the belief that our customers need to be provided as much information as possible about the process and the program. I believe this new design holds the potential to provide the world-class service I pledged to furnish the American people--it will be user-friendly, it will ensure the right decision is made the first time, it will allow decisions to be made and effectuated quickly, and it will be an efficient process. Just as importantly, the new design will also provide our employees with a nurturing environment through empowerment, education, challenge, career opportunity, and professionalism.

As the discussions about our reengineering effort and the future of the disability claim process evolved, I listened to the issues and opinions and the hopes and fears that have been expressed. I heard from SSA and State employees, the public, members of Congress, representatives of other Federal agencies, State officials, union representatives, and various experts in the disability field. I believe that everyone wants something better for the American people. I am convinced that we must be bold in our efforts. Therefore, I have chosen to accept the recommendations of the Agency's Disability Process Reengineering Team which were presented to me on June 30, 1994, with the full understanding that certain aspects of the decisional methodology will require extensive research and testing to determine whether they can be implemented. Because those aspects of decisional methodology that deal with functional assessment, baseline of work, and the evaluation of age require much study and deliberation with experts and consumers, we are making no conclusions about their ultimate place in the disability process. Our implementation plans include the research needed to begin in this area. As more is known, we will reevaluate our planning assumptions. Until then, the concept of a single person as the disability claim manager for all cases cannot be fully implemented.

Instead, we will seek ways of working in teams to provide claimants with the level of service they seek.

The cost of redesigning our disability claim process will not be inexpensive; however, the tangible savings will be worth the investment. The workyear savings will allow us to use current staff to accomplish other pressing workloads and activities of the Agency while avoiding new hiring to replace all those who retire or otherwise leave on their own accord. Thus, we will be able to do our part to reduce the Federal workforce overall. Additionally, with these savings will come such intangibles as improved customer service, an empowered and better trained workforce, and increased public confidence in the process.

It is now time for us to move forward with concrete actions to begin the actual redesign of the way we do business in our disability programs. On July 12, 1994, I announced that Charles A. (Chuck) Jones, the Director of the Michigan Disability Determination Service, had accepted the challenge of managing the implementation of SSA's plan to reengineer the disability process. In that role, he will be responsible for the overall leadership and coordination of the redesign implementation. He will establish timelines and priorities and will provide direction to component efforts as well as to task management teams. As Implementation Manager, Chuck will report directly to me and the Principal Deputy Commissioner.

During the discussions of the Team's proposal, I heard several consistent underlying themes about how our new design should be implemented: we must unify the process; we need enabling information technology; we need to ensure the safety of employees; we must continuously deliver effective training; we must retain the existing Federal/State relationship; and we must develop a simpler methodology for making disability decisions. I am absolutely committed to turning these needs into realities as we move ahead. Some will not be easy, and all will take time and money; however, all will need to be addressed if we are to achieve the successful outcome of the redesign.

As implementation plans are developed and task teams are brought together, we will continue to assess all related activities against the five primary objectives of our redesigned process:

- making the process "user friendly" for claimants and those who assist them;
- making the right decision the first time;
- making the decision as quickly as possible;
- making the process efficient; and
- making the work satisfying for employees.

However, this work will not be done in isolation--internally, we will continue to seek advice on these issues from our Advisory Group, comprised of SSA and DDS executives

and union and association leaders. Externally, we will continue to publicly inform all who are interested and create opportunities for dialogue and consultation.

Special thanks are extended to the Disability Process Reengineering Team whose recommendations are the result of an unprecedented endeavor for this Agency, and I dare say for most Federal agencies. The Team's thousands of hours of interviews, research, analysis, computer modeling, feedback sessions, and revisions have created a daring image for us of what can be if we truly seek to provide world-class service. We must accept their challenge and begin the arduous task of bringing to reality what is now only a concept.

The next few years will be challenging for all of us as we build our redesigned process, but that will not be a new experience for those of you who are employees of SSA and the State DDSs. You have been called upon in the past to rise to the occasion and have always more than met the challenge; your flexibility, resourcefulness, professionalism, and just plain hard work are legendary. Now more than ever, I will need you to be bold and help build a better future for those who seek our services.

  
Shirley S. Chater  
Commissioner  
of Social Security

# CASE FOR ACTION

## Overview

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SSA and the State Disability Determination Services (DDSs) have always striven to provide high-quality, responsive service to the public. In recent years, the disability insurance (DI) and Supplemental Security Income (SSI) claims workload has been the Agency's most challenging problem. SSA has been faced with unprecedented workload increases in both the DI and SSI programs which have severely strained its resources. Despite improvements in productivity by employees in field offices, DDSs, hearing offices, the Appeals Council and the processing centers over the last several years, SSA has had difficulty providing a satisfactory level of service to claimants for disability benefits. SSA recognizes that, in an era of spending limitations and competing social spending priorities, placing more and more resources into the current process is not a viable alternative.

Additionally, demographic changes in the

general population and in the SSA claimant population present challenges as well as opportunities as SSA strives to provide world-class service to its customers. Despite the workload and demographic changes, however, the procedures for processing disability claims have not changed in any important way since the beginning of the DI program in the 1950's and many of the Agency's current practices are based, in large part, on procedures begun 40 years ago. Disability process changes that have evolved over time tend to reflect small, incremental improvements designed to address various pieces of the overall process. It has become increasingly clear that incremental improvements are no longer sufficient to achieve the level of service that will make a substantial difference to disability claimants. Thus, SSA needs a longer-term strategy for addressing service delivery problems in the disability claim process.

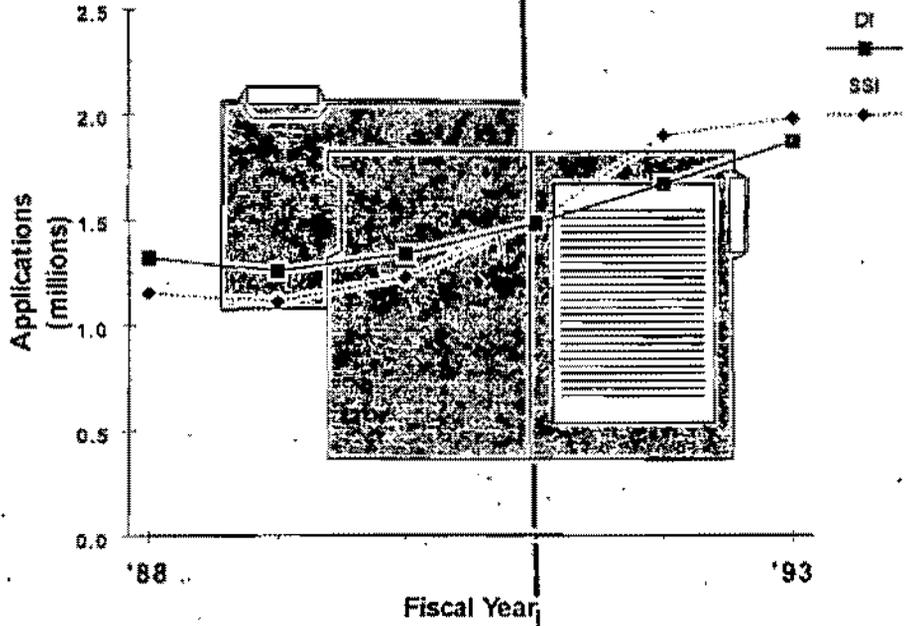
## Workload and Operations Trends

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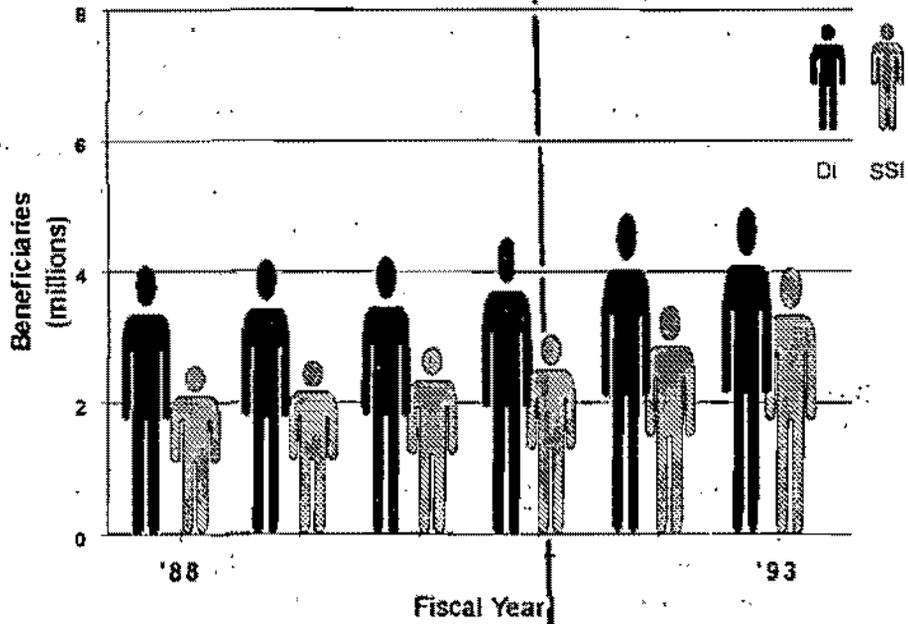
Over the last several years, as workloads have increased dramatically, the disability process has been placed under increasing stress. The upward trend in

the number of claims and the number of beneficiaries awarded is reflected as follows:

### Disability Application Growth

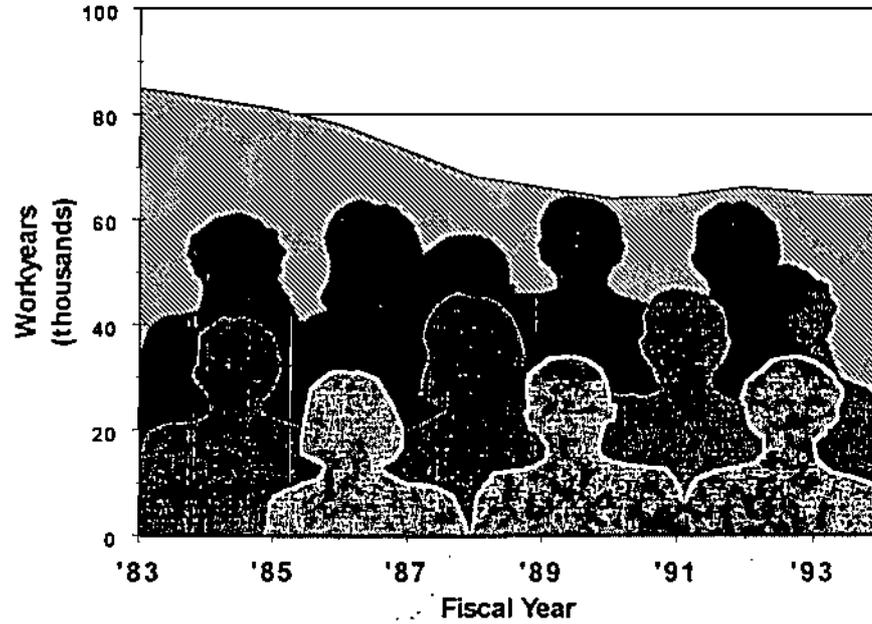


### Disability Beneficiary Growth

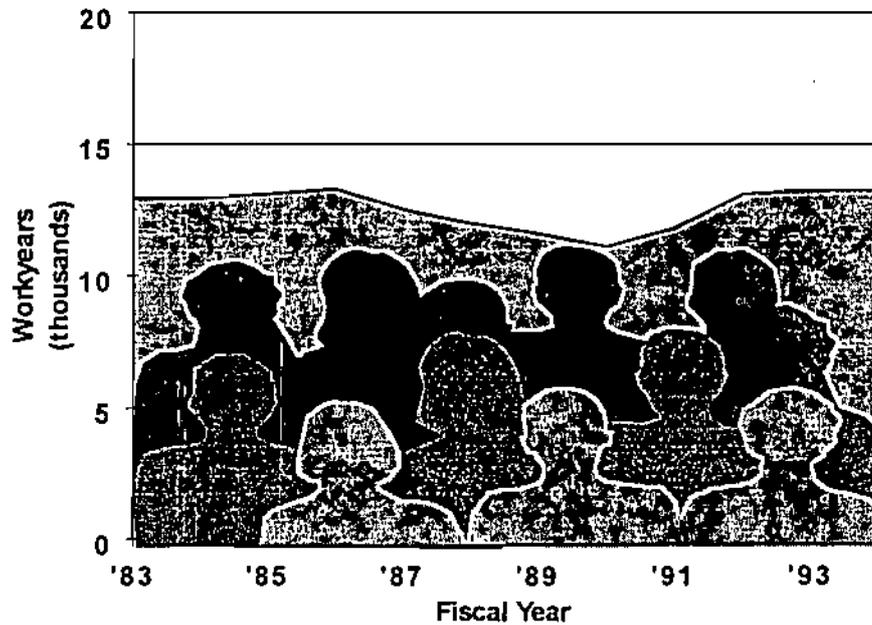


The increase in workload has occurred concurrently with significant downsizing activity in SSA and staffing fluctuations in the State DDSs.

### SSA Staffing Levels



### DDS Staffing Levels

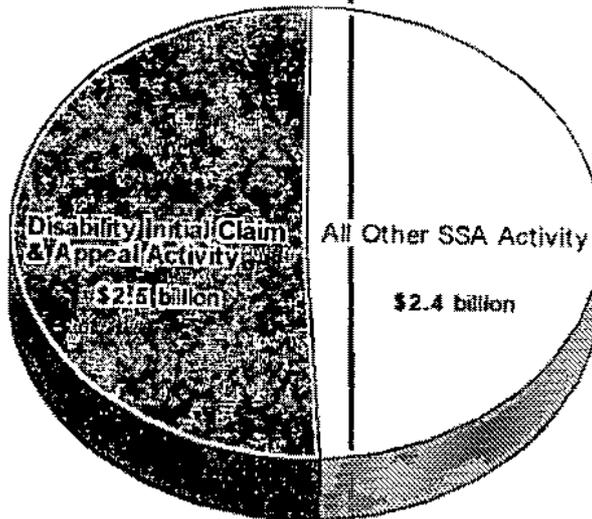


Even with the downsizing, the total costs for processing initial disability and appeals determinations (excluding the costs for processing the *Sullivan v. Zebley* court case) remain enormous —

more than half of the total administrative costs (including DDS costs) for SSA in Fiscal Year (FY) 1993 were devoted to this task.

### Total Administrative Costs

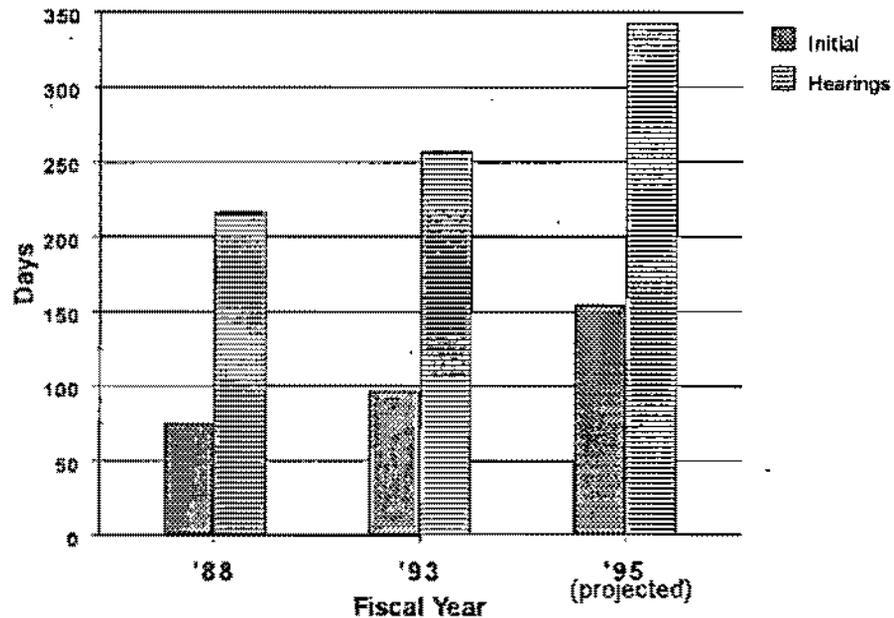
Fiscal Year 1993



Despite these funds, and despite directing a larger percentage of the SSA resources toward disability initial claims and appeals processing in recent years,

average processing times for initial claims, as well as appeals, have escalated dramatically since 1988.

### Average Claims Processing Time



The high workload level is expected to continue and will adversely affect SSA's ability to timely process initial disability claims and appeals. Recent management initiatives to improve service through resource reallocations and productivity enhancements have not been sufficient to deal successfully with the workload demands and it is expected that disability processing times and backlogs will continue to grow under the present process. In FY 1995, it is estimated that 2.9 million initial disability claims will be

forwarded to DDSs for disability determinations—a 69 percent increase over FY 1990 levels. Similarly, in FY 1995, annual requests for administrative law judge (ALJ) hearings will rise to 542,000, a 75 percent increase over FY 1990 levels. The average time to process an initial disability claim (the combined average for both DI and SSI claims) is expected to rise to 154 days in FY 1995; the average time from ALJ hearing request to decision is expected to rise to 342 days in the same period.

## Demographic Trends

American society has changed dramatically since the DI program began in the 1950s. This is reflected in an increased demand for SSA's services, changes in the characteristics of claimants seeking benefits, and new complexities in claim-related workloads and processes.

The demographic character of the SSA disability claimant population has changed as well. The enactment of the SSI program in the 1970's added individuals who have limited or no work histories, increased the number of individuals filing based on disabilities such as mental impairments, and provided for eligibility of disabled children. Additionally, the requirements of the SSI program added complex and time consuming development of non-disability eligibility factors such as income, resources and living arrangements. The 1990 U.S. Supreme Court decision, *Sullivan v. Zebley*, resulted in increased claims for children; children comprised 21 percent of all SSI claims in 1992, up from 11 percent in 1988. Homeless individuals and others with special needs have strained the delivery system. These claimants require significant intervention and assistance to navigate the disability claim process.

A trend in the general population which is reflected in SSA's disability claimant population is the increased number of people in the United States for whom English is not the native language.

Recent national Census data indicate that 1 in 7 people speak a language other than English in the home; this is an increase of almost 38 percent in the last 10 years. SSA will need to accommodate the special communication needs of these claimants in its ongoing claimant contacts and in public information vehicles.

Forty percent of claimants filing for disability benefits and polled in a recent SSA survey had filed for or received benefits from Aid to Families with Dependent Children, welfare or social services within the past year. Approximately three-fourths of them were granted this assistance and three-fourths of those grantees were still receiving assistance when they applied for disability benefits. SSA has the opportunity to develop productive relationships with these social service entities to improve the processing of disability claims for mutual customers.

Technological advances such as personal computers, facsimile machines, electronic mail, and videoconferencing are increasingly available to our claimants, their representatives, medical providers and other third parties involved in the disability process. SSA can take advantage of these capabilities to offer expanded service options and to modernize the ways it interacts with providers of claims-related information and evidence.

## The Current Process

### Slow, Manual Process

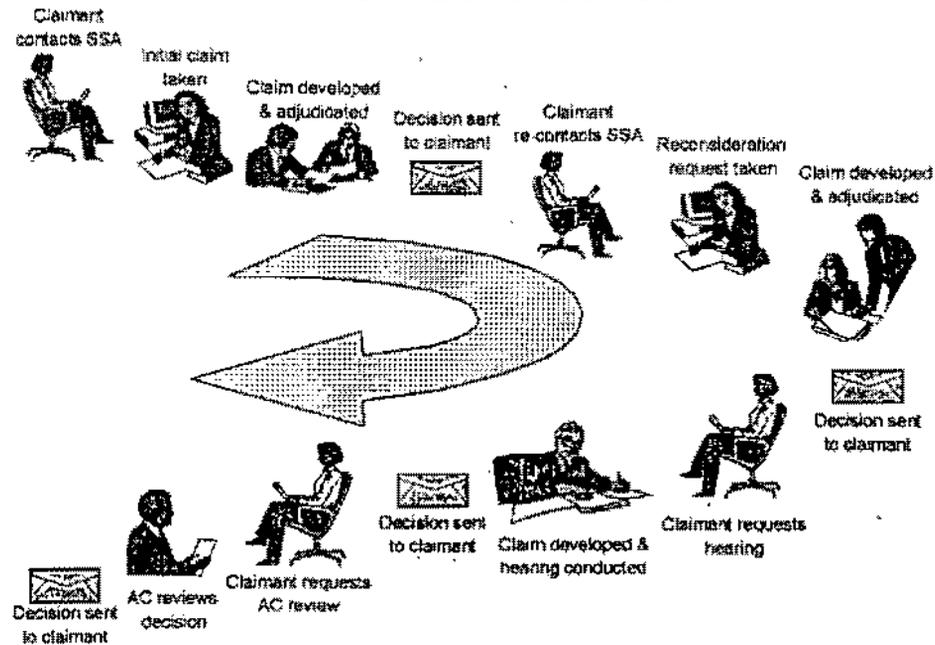
The procedures in the current process have not changed in any significant way since the DI program began in the 1950s, a time when caseloads, demographic characteristics of claimants, types of disabilities, and available technology were radically different. In the 1970s, Congress

federalized State programs of cash assistance to the aged, blind and disabled into the SSI program and added this to the responsibilities of SSA. SSA adopted the DI disability determination procedures for SSI blind and disabled claims.

In the current process, a disability claim passes through from 1 to 4 decisional paths to receive a favorable decision. The initial claim, reconsideration, ALJ

hearing and Appeals Council review levels all involve multi-step uniform procedures for evidence collection, review, and decisionmaking.

## Current 4-Level Process



The process starts at the initial level when an individual first applies for DI and/or SSI benefits on the basis of a disabling physical or mental condition. An individual calls the national toll-free telephone number and is referred to a local SSA field office or visits or calls one of 1,300 local field offices to apply for benefits. Field office personnel assist with application completion, obtain detailed medical and vocational history and screen nonmedical eligibility factors. Field office personnel forward the claim to 1 of 54 State DDSs where medical evidence is developed and a final decision is made regarding the existence of a medically determinable impairment which meets the definition of disability. The decision is made by an adjudicative team consisting of a disability specialist and a program physician.

After possible quality assurance review

in the DDS or in the SSA regional Disability Quality Branch, the claim is returned to the field office; denials are retained pending possible appeal. In FY 1993, 39 percent of initial claims were allowed and sent to 1 of 7 processing centers (which include the Office of Disability and International Operations and the 6 Program Service Centers) for final processing and storage, as well as adjudication of claims for dependents. Allowed SSI claims remain in the field office for payment effectuation and folder retention. A sample of these are reviewed after payment for nondisability quality assurance. According to SSA's computer-based processing time measurements, an initial claim currently takes an average of about 100 days to process from the time of filing until a decision is made. However, from the claimant's perspective, a better understanding of how long the process

takes comes from a 1993 study conducted by SSA's Office of Workforce Analysis, which showed that an average claimant waits up to 155 days from the *initial contact* with SSA until receiving an initial claim *decision notice*. During this period, 16 to 26 employees will handle the claim.

The claimant may request reconsideration of the initial decision within 60 days of receiving the denial notice. In FY 1993, claimants requested reconsideration in 48 percent of denied claims. Local field office personnel receive the reconsideration request, update necessary information, and forward the claim file to the DDS for review, possible medical development, and a medical decision. The reconsideration decision is made by a different adjudicative team than the one that made the initial determination.

After possible quality assurance review in the DDS or in the regional Disability Quality Branch, about 14 percent of these claims are returned to the field office for payment and forwarding to a processing center; the remaining denials are forwarded to the field office for retention, pending possible further appeal. According to SSA's computer-based processing time reports, the average reconsideration takes about 50 days—however, according to the Office of Workforce Analysis study, a claimant has now been involved with the disability process for roughly 8 months from the initial contact with SSA, and up to 36 different employees could have handled the claim.

A claimant can request a hearing before an ALJ within 60 days of receiving an unfavorable reconsideration decision. In FY 1993, claimants requested an ALJ hearing in about 75 percent of all reconsideration denials. By this time, a claimant has usually retained an attorney or other representative to assist in pursuing the claim for benefits. About 75 percent of all claimants retain a representative at the hearing level. Local

field office personnel receive the request for hearing and forward it with the claim file to one of 132 local SSA hearings offices. Hearing office personnel review the file for possible additional development, conduct a hearing, and render a decision.

DI claims allowed at the hearing level are sent to a processing center for payment effectuation and adjudication of claims for dependents, and storage. Allowed SSI claims are returned to the local field office for income and resource development, and payment. Denied claims are forwarded to the Appeals Council for retention pending a possible request for review. According to computer-based reports, the hearing process takes about 265 days. However, according to the Office of Workforce Analysis study, a claimant has been dealing with SSA for over a year and a half at this point in the process.

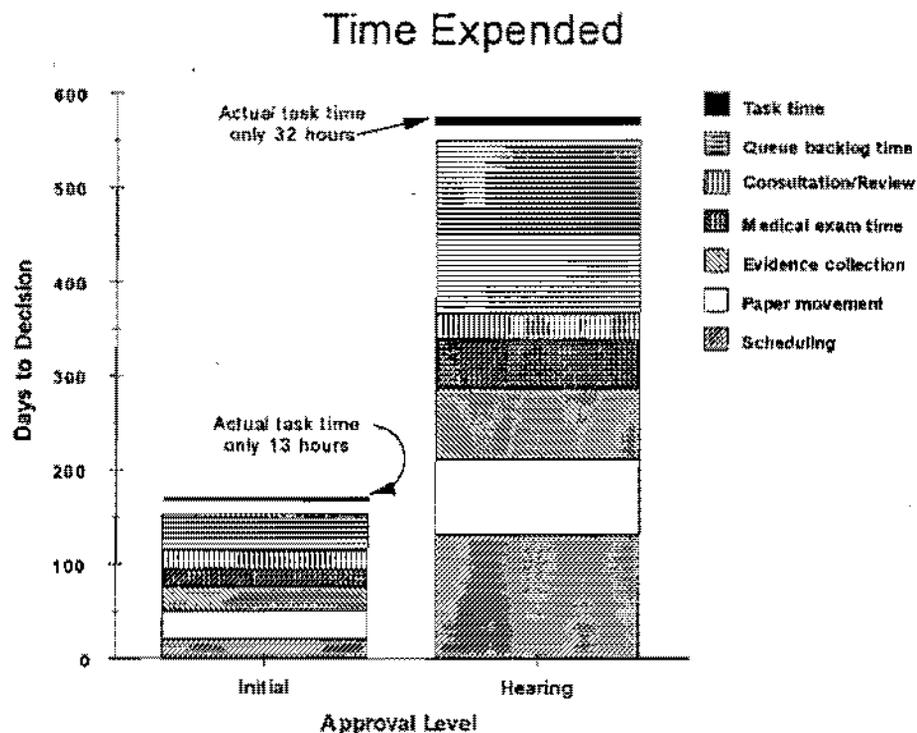
If dissatisfied with the hearing decision, a claimant (or representative) may request Appeals Council review within 60 days of receiving the ALJ decision. In FY 1993, about 23 percent of hearing decisions were unfavorable. The Appeals Council considers about 18 percent of all ALJ dispositions, including cases it reviews on its own motion. Requests for Appeals Council review are typically received directly from the claimant's representative. The Appeals Council may deny or dismiss a request for review, issue a decision, or remand the claim to an ALJ. The Appeals Council remands claims to the ALJ level about 27 percent of the time for subsequent development and decision. Denied claims, representing about 70 percent of the Appeals Council dispositions, are held in the Appeals Council for possible appeal to Federal District court. Allowed claims are sent to a processing center or field office for further action as in hearing cases. According to processing time reports, this part of the process takes on average about 100 days; however, according to the Office of Workforce Analysis study, a claimant has spent almost 2 years

dealing with SSA since initially contacting the Agency.

At least part of the processing time results from the time added as the claim moves from one employee or facility to another (handoffs), and waits at each employee's workstation to be handled (queues). As workloads increase, the amount of time a claim waits at each processing point grows.

"Task time" is the time employees actually devote to working directly on a

claim, rather than the total amount of time it takes for a claimant to receive a final decision. Based on the Office of Workforce Analysis study, a claimant can wait as long as 155 days from the first contact with SSA until receiving an initial claim decision notice—of which only 13 hours of this is actual task time. The same study reveals a claimant can wait as long as 550 days from that initial contact through receipt of the hearing decision notice—of which only 32 hours is actual task time.



### Complex, Confusing Process

Many applicants enter the SSA disability process uninformed about the process itself and the definition of disability. They are unaware of the criteria for establishing disability and the evidence they will be required to submit. Even third parties and advocate organizations, often more knowledgeable than the general public about SSA procedures, experience difficulty obtaining meaningful information about the status of their clients' claims, finding that they often are transferred from one employee

to another.

Disability claimants face a "one size fits all" approach to the intake and processing of their claim, finding themselves answering questions they believe are intrusive and irrelevant to their claim. Front-line employees currently devote hours to completing forms and obtaining information which may not be necessary for a finding of disability. Claimants often do not understand what happens to the claim

after initial contact with SSA and view multiple requests for medical information with annoyance. Often claimants do not understand how the decision was made and, therefore, believe that it was reached arbitrarily. If the claim is approved, whether at the initial or appellate level, claimants and their representatives, as well as front-line employees, are concerned about the complicated procedures and length of time it takes to effectuate payment and entitle eligible dependents.

SSA employees, claimants, and other interested parties all agree that the current process takes too long to provide applicants a decision, and leaves them confused about who has responsibility for their claim, and puzzled about the status of their claim during various points in the process. Additionally, nearly all believe that many claimants can and should assume more responsibility for submitting evidence and pursuing their claim.

Most view the reconsideration step as little more than a rubber stamp of the initial determination, creating additional work for employees and yet another bureaucratic obstacle for claimants and their representatives. Some believe a

face-to-face interview with the decisionmaker is vital to reaching a fair, accurate determination; others believe just as strongly that the decision should be reached on the basis of a paper review, and that a face-to-face interview can lead to subjective decisions that are not based on objective criteria. Quality reviews and Appeals Council reviews are often mentioned as areas where opportunities exist for streamlining and improving the current process.

Claimants and their representatives have learned their chances for a favorable decision improve if they appeal their claim to an ALJ. The public, in particular, believes that it is necessary to hire an attorney to maneuver through the appeals process, and voices resentment at having to do so. Higher allowance rates at the ALJ level lead to the perception that different adjudicative standards apply at the initial and appeals levels. A variety of factors may be contributing to this. The facts of many cases change over time as a claimant's condition changes. ALJs often have access to information not considered at lower levels in the process because earlier decisionmakers are not as likely to have face-to-face interaction with the claimant.

### Contributors to Complexity

The collection of medical evidence presents problems as the case is developed, accounting for a considerable portion of the total time involved in disability claim processing. Health care providers who are a claimant's treating source often do not understand the requirements for establishing disability, and find medical evidence request forms confusing and repetitive. They believe that evidence requests burden them with far too much paperwork and offer far too little in the way of compensation for the time invested. Adjudicators often find that evidence is primarily treatment-oriented and fails to provide either the highly specialized clinical findings or the functional information that is required by the regulations. To compensate for poor

or missing medical evidence, DDSs purchase consultative examinations, devoting substantial resources to scheduling, purchasing, and processing these examinations.

Once the medical evidence has been collected, the methodology used by disability decisionmakers is complex and controversial. The current sequential evaluation process, which was originally designed to identify and evaluate cases in a simple, rapid and consistent fashion has grown increasingly complex as the result of court decisions and changes in medical technology. This complexity has, in turn, contributed to the increasing difficulty and fragmentation in other portions of the disability process.

including intake, evidence collection, and appeals.

For example, the Listings of Impairments was originally designed to highlight readily identifiable disabling impairments. Many of the Listings have since evolved into complex and highly detailed diagnostic requirements, demanding specialized medical evidence that may not be readily available from treating sources. Some, but not all, of the Listings consider the functional consequences of an impairment; however functional considerations vary significantly among the Listings. Additionally, in assessing an individual's functional abilities at the later steps in the sequential evaluation, adjudicators collect and analyze evidence from a multitude of different, and often conflicting, sources including: objective

clinical and laboratory findings; treating source opinions and other third-party statements considered to be consistent with the objective evidence; and the individual's description of his or her limitations. The development of extensive medical evidence in every case impedes timely and efficient decisionmaking. The varying approaches to assessing a claimant's functional ability that are required at different steps in the sequential evaluation, along with the nature and types of evidence that adjudicators may rely on to assess function often lead to different interpretations of the same evidence by different adjudicators. Vocational rules originally designed to provide a structured approach to decisionmaking have grown increasingly complex, leading to varying interpretations and inconsistent decisions.

### **Fragmented Process**

The fragmented nature of the disability process is driven by and exacerbated by the fragmentation in SSA's policy making and policy issuance mechanisms. Policy making authority rests in several organizations with few effective tools for ensuring consistent guidance to all disability decisionmakers. Different vehicles exist for conveying policy and procedural guidance to decisionmakers at different levels in the process. While the standards for disability decisionmaking are uniform, they are expressed in different wording in the various policy vehicles.

Training on disability is not delivered in a consistent manner, nor is it provided simultaneously to disability decisionmakers across or among levels in the process. Mechanisms for reviewing application of policy among levels of the process are fragmented and inconsistent. Review of DDS decisions is heavily weighted toward allowances; no systematic quality assurance program is in place for hearing decisions although the opportunity for feedback from the

Appeals Council or from the courts is heavily weighted toward denials.

The organizational fragmentation of the disability process creates the perception that no one is in charge of it. SSA measures the process from the perspective of the component organizations involved, rather than the perspective of the claimant. Multiple organizations (field offices, DDSs, hearings offices, Appeals Council operations, and processing centers) have jurisdiction over the claim at various points in time, with each line of authority managing toward its own goals without responsibility to the overall outcome of the process. Additionally, the impact of one component's work product on other components is not measured, further contributing to the fragmentation of the process. Each component's narrow responsibilities reinforce a lack of understanding among component employees of the roles and responsibilities of other employees in different components.

## The Need For A Redesigned Disability Claim Process

### Redesign Technique

Concerns about the Agency's business processes generally, and the quality of service in the disability claim process in particular, led SSA leadership to the conclusion that a disability process reengineering effort was critical to the SSA goal of providing world-class service to its customers. The National Performance Review, headed by the Vice President, directed improvement of the SSA disability process as a key service initiative for the Federal government.

Leading private sector organizations have used process reengineering to identify and quickly put in place dramatic improvements in their operations. The objective of a reengineering review is to fundamentally rethink and radically redesign a business process from start to finish, so that it becomes many times more efficient and, as a result, significantly improves service to the organization's customers. By focusing on the disability claim process as a single business process, SSA hoped to cut across the organizational lines and multiple components that handle the

many pieces of the disability process.

A project team composed of 18 Federal and State employees, under the direction of an SSA senior executive, assembled at SSA Headquarters in October 1993 to conduct the disability claim process reengineering review. With the guidance of an Executive Steering Committee, the Team was challenged to fundamentally rethink the way SSA processes disability claims. The Team's initial findings and proposal, issued in March 1994, for a redesigned disability claim process were widely shared during a 60-day public comment period. Based on the comments received, the Team presented a revised proposal to the Commissioner of Social Security on June 30, 1994. After extensive consultation with individuals and organizations in the internal and external disability community, the Commissioner accepted the Team's recommendations for a redesigned disability process. A summary of the methodology used to redesign the disability claim process is included in Appendix I.

### New Process Goals and Expectations

The Commissioner established five primary objectives against which SSA will measure the success of a redesigned disability claim process:

- the process is user friendly for claimants and those who assist them;
- the right decision is made the first time;
- decisions are made and effectuated quickly;
- the process is efficient; and
- employees find the work satisfying.

By focusing on these objectives, the

redesigned process replaces an existing process that is slow, labor-intensive, and paper reliant with a seamless claim process that makes better use of technology, eliminates fragmentation and duplication, promotes more flexible use of resources, and results in dramatic improvements in public service. With the redesigned process, SSA has embarked on an era of change that will revitalize and streamline the way it delivers disability claim services to the public to achieve greater quality, accuracy, speed and efficiency. A detailed description of the redesigned disability claim process is presented in the following section.

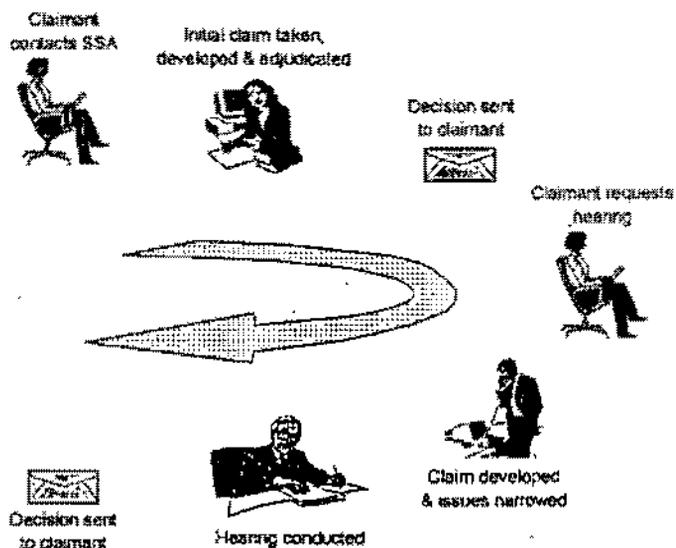
# DESCRIPTION OF THE NEW PROCESS

## Overview

Claimants for disability benefits under the new process will be provided a full explanation of SSA's programs and processes at the initial contact with SSA. Claimants will be offered a range of options for filing a claim and conferring with decisionmakers, using various modes of technology to interact with SSA. Claimants, who are able to do so, along with third parties and representatives who act on their behalf,

will assist in the development of their claims, deal with a single contact point in the Agency, and have the right to a personal interview with decisionmakers at each level of the process. The number of steps will be consolidated and the issues on appeal will be focused. If the claim is approved, the effectuation of payment to the claimant, eligible dependents and the representative will be streamlined.

## Redesigned 2-Level Process



The new process will result in correct decisions at the earliest possible point in the process. A correct disability decision is one that appropriately considers whether an individual does or does not meet the factors of entitlement for disability as defined by SSA's statute, regulations, rulings and policies. Correct decisions in the new process depend on: a simplified decision methodology that

provides a common frame of reference for deciding disability at all levels of the process; consistent direction and training to all adjudicators; enhanced and targeted collection and development of medical evidence; an automated and integrated claim processing system that will assist adjudicators in evidence gathering, analysis and decisionmaking; and a single, comprehensive quality

review process across all levels. The goal of the new process is to guide all adjudicators at all levels of the process, who will be using the same standards for decisionmaking, to making correct decisions in an easier, faster, and more cost-effective manner.

A disability claim manager will handle most aspects of the disability claim at the initial level, thus eliminating many steps caused by numerous employees handling discrete parts of the claim (handoffs) and the time lost as the claim waits at each employee's workstation to be handled (queues). This will reduce the time needed to rework files and redevelop information from the same evidentiary sources. Levels of appeal will be combined and improved, reducing the need to redevelop nonmedical eligibility factors after a favorable decision because less time will have elapsed since initial filing.

The new process will enable the current work force to handle an increased number of claims, freeing the most highly specialized staff (physicians and ALJs) to work on those cases and tasks that make the best use of their talents, and targeting expenditures for medical evidence to those areas most useful in determining disability.

Employees will perform a wider range of functions, using their skills to their full potential, enabling them to meet the needs of claimants and minimize unnecessary rework. The new process will facilitate employees' ability to do the total job by providing technology and the training and support to use that technology. *(For ease of reference, references in this plan to "SSA" or "employees" include both Federal and State employees who participate in the disability process.)*

## Process Entry and Intake

### Customized Intake and Entry

The disability claim entry and intake processes will reflect the SSA commitment to providing world-class service to the public. The hallmarks of the process will be accessible, personal service that ensures timely and accurate decisions. SSA will work to make potential claimants better informed about the disability process and fully prepare them to participate in it. Every effort will be made to provide services to meet the needs of culturally diverse, non-English

speaking claimants. SSA will also be flexible in providing modes of access to the claim process that best meet the needs of claimants and the third parties and representatives who act on their behalf. SSA will provide claimants with a single point of contact for all disability claim-related business. Finally, SSA will ensure that the disability decisionmaking process promotes timely and accurate decisions.

### Making Program Information Available

SSA will make available to the general public comprehensive information packets about the DI and SSI disability programs. *(For ease of reference, references in this plan to the SSI Disability Program include the Program for those who are blind.)* The packets will include information about the purpose of the disability programs; the definition of disability; the basic requirements of the programs; a description of the adjudication process;

the types of evidence needed to establish disability; and the claimant's role in pursuing a claim. The packets may be customized locally to include referral information about other programs and resources for legal representation. The goal is to target the information to likely beneficiaries and to ensure that potential claimants and other groups involved in the disability process have a better understanding of SSA disability programs, their medical and nonmedical

requirements, and the nature of the decisionmaking process. This should result in reduction of general inquiries from members of the public unfamiliar with SSA disability programs and increase the number of claimants who enter the disability process knowledgeable and prepared to assume responsibility for pursuing their claims.

SSA will make disability information packets commonly available in the community, both at facilities frequented by the general public (libraries, neighborhood resource centers, post offices, the Department of Veterans Affairs offices, and other Federal government installations) and at facilities frequented by potential claimants (hospitals, clinics, other health care providers, schools, employer personnel offices, State public assistance offices, insurance companies, and advocacy groups or third-party organizations that assist individuals in pursuing disability claims). SSA studies have shown that claimants frequently rely on advice from their physicians and from State public assistance personnel in deciding whether to file a claim for disability benefits. Therefore, SSA will make a special effort to target its public information activities

at these and other known sources of referrals for claims. SSA will also make the disability information packets available electronically.

In addition to comprehensive program information, the packets will describe the types of information that a claimant will need to have readily available when the individual files a claim. It will also contain two basic forms: the first, designed for completion by the claimant, will include general identifying information and will serve as the claimant's starter application for benefits; the second, designed for completion by the treating source(s), will request specific medical information about a claimant's alleged impairments. SSA will encourage claimants who are able to do so to review the information in the packet and have the basic forms completed prior to telephoning or visiting an SSA office to apply for disability benefits. Claimants will be encouraged to immediately submit starter applications to protect the filing dates for benefits. The starter application will serve as a claim for both programs, but it will include a disclaimer should the claimant want to preclude filing for benefits based on need (i.e., SSI).

### **Claimants Will Choose Mode of Entry**

The disability claim entry process will be multi-faceted, allowing claimants and third parties and representatives who assist them the maximum flexibility in deciding how they will participate in the process. Claimants may choose to enter the disability claim process by telephoning the SSA toll-free number, electronically, by mail, or by telephoning or visiting a local office. Claimants may also rely on third parties to provide them assistance in dealing with SSA. Finally, claimants may formally appoint representatives to act on their behalf in dealing with SSA. SSA field managers will also have the flexibility to tailor the various service options to their local conditions, considering the needs of client populations, individual claimants, and the availability of third parties who

are capable of contributing to the application process.

If an individual submits a starter application by mail or electronically, SSA will contact the claimant to schedule an appointment for a claim intake interview or, at the claimant's option, conduct an immediate intake interview by telephone.

If an individual telephones SSA to inquire about disability benefits, the SSA contact will explain the requirements of the disability program, including the SSA definition of disability, and provide a general explanation of evidence requirements. The SSA contact will determine whether the individual has the disability information packet, and mail it or advise the claimant regarding possible

means of electronic access. If an individual indicates a desire to file a claim at that time, the SSA contact will complete the starter application available on-line as part of the automated claim processing system to protect the claimant's filing date and schedule an appointment for a claim intake interview. The interview may be in person or by telephone at the claimant's option. If the individual has no medical treating sources, the SSA contact will annotate this information within the on-line claim record.

If a claimant visits an SSA office, the SSA contact will refer the claimant for an immediate claim intake interview or, at the claimant's option, complete the starter application and schedule a future appointment for an intake interview.

In all cases, appointments for claim intake interviews will be made available within a reasonable time period, generally 3 to 5 working days, but no later than two weeks.

Local management will determine how to best accommodate claimants' needs in learning about the disability process and completing a claim intake interview. Depending on an individual's circumstances, such accommodation may involve: referral to the nearest location for obtaining a disability information packet which can then be mailed in; an immediate telephone or in-person interview; arranging for an on-site visit from an SSA representative; or referral to appropriate third parties who can provide assistance. Additionally, depending on the nature of the individual's disability, SSA may encourage the individual to file in person when it appears that a face-to-face interview will assist in the proper claim intake and development; however, face-to-face interviews will not be required in every claim. Face-to-face interviews,

A disability claim manager will have responsibility for the complete processing of an initial disability claim.

when considered necessary by either the claimant or SSA, can also be accomplished via videoconferencing. In any case, SSA will make every reasonable effort to meet the needs of the claimant in completing the application process. Every effort will be made to provide services to members of the public who have limited knowledge of English.

Similarly, local managers will modify the claim entry and intake process to provide maximum flexibility for representatives who act on behalf of claimants or third parties who can assist claimants in completing the application process. Such accommodations may include, but are not limited to: 1) using automated means to interact with SSA to protect a claimant's date of filing (e.g., telephone, fax, or E-mail); 2) providing appointment slots for third parties to accompany claimants to interviews or to provide assistance during telephone claims on a claimant's behalf; 3) out-stationing SSA personnel at a third-party location to obtain applications and/or medical evidence, when appropriate; and 4) providing "open appointment" scheduling to permit claimants to contact SSA within a flexible band of time. Interested third parties will be encouraged to participate in the development of claims.

Local managers will also conduct outreach efforts that are designed to meet the needs of hard-to-reach populations or assist those individuals unable to access the SSA claim process without considerable intervention. As appropriate, outreach efforts may be facilitated through videoconferencing, teleconferencing or other electronic methods of obtaining and processing claim information to provide timely service despite claimants' geographic or social isolation:

The disability claim manager will be a highly-trained individual who is well-versed in both the medical and

**Disability  
Claim  
Manager**

nonmedical aspects of the disability programs and has the necessary knowledge, skills, and abilities to conduct personal interviews, develop evidentiary records, and adjudicate disability claims to payment. However, the disability claim manager will also be able to call on other SSA resources, including medical and technical support personnel, to provide advice and assistance in the claim process.

Disability claim managers will rely on an automated claim processing system that will permit them to: gather and store claim information; develop both medical and nonmedical evidence; share necessary facts in a claim with medical consultants and specialists in nonmedical or technical issues; analyze evidence and prepare well-rationalized decisions on both medical and nonmedical issues; and produce clear and understandable notices that accurately convey all necessary information to claimants. In making decisions, disability claim managers will use a simplified decision methodology that effectively streamlines evidence collection, and will rely on standards for decisionmaking that are used at all levels of the process.

### **Scope of Duties**

The broad scope of the disability claim manager's duties and responsibilities, as outlined above and discussed in more detail in the following sections, presupposes a well-trained, skilled, and highly motivated workforce that has the program tools and technological support to issue quality decisions. Although disability claim managers will work exclusively within the disability programs, they will perform multiple tasks instead of singular activities, enabling them to experience the direct relationship between their actions and the final product. Varying levels of job complexity provide the opportunity for personal development, growth, and learning.

In carrying out their duties and responsibilities, disability claim managers

The disability claim manager will be the focal point for claimant contacts throughout the claim intake and adjudication process. The disability claim manager will explain the disability programs to the claimant, including the definition of disability and how SSA determines if a claimant meets disability requirements. The disability claim manager will also convey what the claimant will be asked to do throughout the process; what the claimant may expect from SSA during this process, including anticipated timeframes for decision; and how the claimant can interact with the disability claim manager to obtain more information or assistance. The disability claim manager will advise the claimant regarding the right to representation and provide the appropriate referral sources for representation. The disability claim manager will also advise the claimant regarding community resources, including the names of organizations that could help the claimant pursue the claim. The goal will be to give the claimant access to the decisionmaker and allow for ongoing, meaningful dialogue between the claimant and the disability claim manager.

will work in a team environment with internal medical and nonmedical experts, who provide advice and assistance for complex case adjudication, as well as technical and other clerical personnel who may handle more routine aspects of case development and payment effectuation. Where disability team members cannot be physically co-located, they can share information via the automated claim processing system and remain in communication using telephones or videoconferencing. Each disability team member will have at least a basic familiarity with all the steps in the process and an understanding of how he or she complements another's efforts; team members will be able to draw upon each other's expertise on complex issues.

In this team environment, and with the proper training, program tools (a simplified decision methodology and one set of standards for decisionmaking) and technological support, one individual should be able to handle the duties and responsibilities of the disability claim manager. An individual employee as the disability claim manager is basic to the objective of a single point of Agency contact for claimants.

However, in the near term, it may be necessary to consider whether the duties of a disability claim manager may be more appropriately carried out by more than one individual and, therefore, whether it is necessary to expand the "disability team" described above to

include additional employees. Claim complexity, customer service needs, and service area location may dictate a need for flexibility in delineating the specific duties of the individuals who comprise the members of the disability team. In the near term, apprentice positions will be developed in which employees perform one or more duties of the disability claim manager while gaining experience and qualifying for greater responsibility. As the program tools and technological support, which are the underpinnings of the new process, are fully implemented, it is envisioned that team duties and positions will be modified and consolidated as necessary to fully realize the goal of an individual employee as disability claim manager.

## Process Flexibility

The disability claim manager will conduct a thorough screening of the claimant's medical and nonmedical eligibility factors. If the claimant appears ineligible for either disability program based on the claimant's allegations and evidence presented or available at the time of the claim intake interview, the disability claim manager will explain this to the claimant. However, the decision regarding whether to file an application will be the claimant's alone and the disability claim manager will not discourage a claimant from filing an application. If the claimant decides not to file a claim, the disability claim manager will follow existing procedures for closing out an oral inquiry.

If the claimant decides to file, the disability claim manager will complete appropriate application screens from the automated and fully integrated (DI and SSI) claim processing and decision support system. Impairment-specific questions will assist the disability claim manager in obtaining information that is relevant and necessary to a disability decision. Based on the claimant's statements and the evidence that is available at the interview, the disability claim manager will determine the most effective way to process the claim. If the

evidence is sufficient to decide the claim, the disability claim manager will take necessary action to issue a decision and, if necessary, effectuate payment. The disability claim manager will determine what additional evidence is required to adjudicate the claim and will take steps to obtain that evidence. Such steps may include asking the claimant to obtain further medical or nonmedical evidence if the claimant is able to do so, requesting medical evidence directly from treating sources, or ordering further medical evaluations. As in the current process, SSA will pay for the reasonable cost of providing existing medical evidence. If the claimant has a formal representative, the representative will have the responsibility to develop medical and nonmedical evidence.

The disability claim manager will decide whether to defer nonmedical development (e.g., requesting SSI income and resource information, or developing DI dependents' claims) or do it simultaneously with development of the medical aspects of the claim. In making this decision, the disability claim manager will take into account the type of disability alleged, evidence and other information presented by the claimant, and other relevant circumstances, e.g.,

terminal illness, homelessness or difficulty in recontacting the claimant. Because the disability claim manager maintains ownership of the claim throughout the initial decision-making process, the disability claim manager will be in the best position to choose the most efficient and effective manner of providing claimants with timely and accurate decisions while meeting claimants' individual service needs.

Although the disability claim manager will be responsible for the adjudication of an initial claim, the disability claim manager will call in other staff resources, as necessary. With respect to disability decisionmaking, the disability

claim manager will, in appropriate circumstances, refer claims to medical consultants to obtain expert advice and opinion. SSA will develop guidelines to assist the disability claim manager in determining when expert medical advice is appropriate. Similarly, other staff resources will be called upon for technical support in terms of certain claimant contacts and status reports; development of nondisability issues including auxiliary claims or representative payee issues; and payment effectuation. However, the disability claim manager will make final decisions on both the medical and nonmedical aspects of the disability claim.

### **Claimant Partnership**

Throughout the disability claim process, SSA will encourage claimants to be full partners in the processing of their claims. Many claimants are able to obtain the documentation necessary to develop their record, either on their own or with the assistance of a third party. Others have substantial difficulty doing so, and may have no third party to assist them. Given the range of claimant capabilities, SSA will retain ultimate responsibility for development of claims when claimants are not formally represented.

To the extent that they are able, claimants and their families and other personal support networks will actively participate in the development of evidence to substantiate their claim for disability benefits. SSA will provide assistance and/or engage third-party

resources, when necessary and appropriate. SSA will keep claimants informed of the status of their claims, advise claimants regarding what additional evidence may be necessary, and inform claimants what, if anything, they can do to facilitate the process.

At the completion of the claim intake interview, the disability claim manager will issue a receipt to the claimant that will identify what to expect from SSA and the anticipated timeframes. It will also identify what further evidence or information the claimant has agreed to obtain. Finally, it will provide the name and telephone number of the disability claim manager for any questions or comments which the claimant may have, including any difficulty in obtaining the information the claimant agreed to obtain.

### **Third Parties**

Certain third-party organizations may be willing to provide a complete disability application package to SSA. Based on local management's assessment of service area needs and the availability of qualified organizations, SSA will recognize third-party organizations who are capable of providing a complete application package, including appropriate application forms and

medical evidence necessary to adjudicate a disability claim. In such claims, SSA will permit the third party to identify potential claimants, screen for medical and nonmedical criteria, and contact SSA to protect the filing date. The third party will interview the claimant; complete all applications and related forms; obtain completed treating source statements; and obtain additional

medical evaluations, when appropriate. Using procedures agreed on with local management, the third party will submit claims for adjudication by a disability claim manager. SSA will monitor such third parties to ensure that quality service is provided to claimants and to prevent fraud. SSA may establish rules, standards, and procedures for third-party interaction with claimants and SSA. Third parties may be required to undergo periodic program, procedural or software training, and may be required to meet standards for staffing and automation support. In individual cases, disability

claim managers may elect to contact the claimant for the purpose of verifying identity or other claim-related issues, as appropriate. SSA will also perform ongoing document verification on a sample basis to assure the integrity of claims submitted by third parties. The automated claim processing system will facilitate effective monitoring of the claim-taking and evidence submission practices of third parties by permitting random and/or targeted selection of claim files involving specific third parties or specific types of evidence.

### **Personal Interview with Claimant**

When the evidence does not support an allowance, the disability claim manager will issue a predecision notice advising the claimant of what evidence has been considered and providing the opportunity to submit further evidence, if any, and/or the opportunity for a personal interview within 10 calendar days. The predecision notice will further advise the claimant that if he or she does not submit evidence or request a personal interview within the 10 days, the claim will be decided based on the evidence of record. If the claimant requests a personal interview, the disability claim manager will conduct the interview in person, by videoconference, or by telephone, as the disability claim manager determines is appropriate under the circumstances. In appropriate circumstances, this predecision interview may be held concurrently with the initial intake interview. If the claimant identifies

further available evidence, the disability claim manager will advise the claimant to obtain the evidence if the claimant is able to do so or, as necessary, assist the claimant in obtaining it. The claimant will be advised of the specified timeframes for submitting additional evidence.

In preparing the predecision notice, the disability claim manager will rely on existing information available on-line as part of the automated claim processing and decision support system. As part of the evidence gathering process, the disability claim manager will have previously analyzed all the medical and non-medical information gathered, and entered the pertinent data into the electronic claim record. The decision support system will use the accumulated data in the electronic record to assist the disability claim manager in producing the predecision notice.

### **"Statement of the Claim"**

The initial disability determination will use a "statement of the claim" approach. The statement of the claim will set forth the issues in the claim, the relevant facts, the evidence considered, including any evidence or information obtained as a result of the predecision notice, and the rationale in support of the determination. The statement of the claim not only reflects SSA's commitment to fully explaining the basis for its action but also recognizes that

claimants need clear information about the basis for the determination to make an informed decision regarding further appeal.

As with the predecision notice, much of the information that will provide the basis for the statement of the claim will be available on-line as part of the automated claim processing and decision support system. Adjudicators will create the statement of the claim and whatever

supplementary information is necessary for a legally sufficient notice to the claimant based on the information in the decision support system. For allowance decisions, the statement of the claim will be more abbreviated than for denial decisions; however, it will contain sufficient information to facilitate quality assurance reviews and/or continuing disability reviews. The statement of the claim will be part of the on-line claim record and will be available to other adjudicators as the basis and rationale for the Agency's action, if the claimant seeks further administrative review.

In making initial disability determinations, disability claim managers will rely on standards for decisionmaking that are used at all levels of the process. SSA will develop a single presentation of all substantive policies used in the determination of eligibility for benefits and all decisionmakers will be bound by these same policies. These policies will be published in accordance with the Administrative Procedure Act. Expert systems will be developed to facilitate the development and delivery of disability policy as an integrated part of the automated claim processing system.

## Disability Decision Methodology

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### Promoting Consistent, Equitable, and Timely Decisions

SSA must have a structured approach to disability decisionmaking that takes into consideration the large number of claims (2.7 million initial disability decisions in FY 1994) and still provides a basis for consistent, equitable decisionmaking by adjudicators at each level. The approach must be simple to administer, facilitate consistent application of the rules at each level, and provide accurate results. It must also be perceived by the public as straightforward, understandable and fair. Finally, the approach must facilitate the issuance of timely decisions.

As described further below, the goal of the new decisionmaking approach is to focus decisionmaking on the functional consequences of an individual's medically determinable impairment(s). The new process will assess an individual's functional ability, assess it once in the process, do it directly rather than indirectly, and rely on standardized functional assessment instruments to do so. By focusing on function, the new approach will permit both providers of medical evidence and adjudicators at all levels of the process to use a consistent frame of reference for deciding disability, regardless of the diagnosis. It will also facilitate evidence collection by lessening

the need for voluminous medical records and, instead, look at the consequences of medical findings, i.e., function. Ultimately, adjudicators will make correct decisions in an easier, faster, and more cost-effective manner.

The cornerstone of the new approach is, of course, the statutory definition of disability. Under the statute, disability (for adults) means the:

"...inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months...An individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy..." (§ 223(d) of the Social Security Act).

## Four-Step Evaluation Process for Adults

The new decisionmaking approach is the foundation on which SSA will base the claim intake process and evidence collection. The focus will be, first, to document the medical basis for concluding that an individual has a medically determinable physical or mental impairment. Second, once the evidence establishes a medically determinable impairment(s), decisionmakers will, in most cases, use additional medical findings to determine the link between the disease or impairment and the loss of function.

The disability decision methodology will consist of four steps that flow from the statutory definition of disability. They are:

- Step 1 — Is the individual engaging in substantial gainful activity?  
If yes, deny.  
If no, continue to Step 2.
- Step 2 — Does the individual have a medically determinable physical or mental impairment?  
If no, deny.  
If yes, continue to Step 3\*.
- Step 3 — Does the individual have an impairment included in the Index of Disabling Impairments i.e., an impairment that clearly restricts functional ability to a degree that the individual is unable to engage in substantial gainful activity without measuring the individual's functional ability?  
If yes, allow\*.  
If no, continue to Step 4.
- Step 4 — Does the individual have the functional ability to perform substantial gainful activity?

If yes, deny.  
If no, allow\*.

*\*An impairment must meet the duration requirement of the statute; a denial is appropriate for any impairment that will not be disabling for 12 months.*

### Step 1 — Engaging in Substantial Gainful Activity

Any individual who is engaging in substantial gainful activity will not be found disabled regardless of the severity of the individual's physical or mental impairments. Under the new approach, SSA will simplify the monetary guidelines for determining whether an individual who is an employee (except those filing for benefits based on blindness) is engaging in substantial gainful activity. In making this determination, SSA will evaluate the work activity based on the earnings level that is comparable to the upper earnings limit in the current process (i.e., \$500). A single earnings level will simplify the evidentiary development necessary to evaluate work activity and establish the appropriate onset date of disability. Additionally, SSA will continue to exclude impairment-related work expenses in evaluating whether an individual's earnings constitute substantial gainful activity. SSA will continue to evaluate whether work activity is done under special conditions and/or is subsidized. Finally, SSA will continue to use separate earnings criteria to evaluate the work activity of blind individuals in the DI program as in the current process.

### Step 2 — Medically Determinable Impairment

Because the statute requires that disability be the result of a medically determinable physical or mental

impairment, the absence of a medically determinable impairment will justify a finding that the individual is not disabled. Under the new approach, decisionmakers will consider whether an individual has a medically determinable impairment or combination of impairments, but will no longer impose a threshold "severity" requirement. Rather, the threshold inquiry will be whether the individual has a medically determinable physical or mental impairment or combination of impairments. To establish the presence of a medically determinable impairment, evidence must show an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

Decisionmakers will continue to evaluate the existence of a medically determinable impairment based on a weighing of all evidence that is collected, recognizing that neither symptoms nor opinions of treating physicians alone will support a finding that the individual has a medically determinable impairment or combination of impairments. There must be medical signs and findings established by medically acceptable clinical or laboratory diagnostic techniques which show the existence of a physical or mental impairment or combination of impairments. Depending on the nature of an individual's alleged impairment(s), SSA will consider the extent to which medical personnel other than physicians can provide evidence of a medically determinable impairment.

There will be an exception to the requirement that evidence include medically acceptable clinical and/or laboratory diagnostic techniques. This will occur when, even if SSA accepted all of the individual's allegations as true, SSA still could not establish a period of disability; under these circumstances, SSA will not require evidence to establish the existence of a medically determinable impairment. For instance, if an individual describes a condition as

one that will clearly not meet the 12-month duration requirement, (e.g., a simple fracture), SSA will deny the claim on the basis that even if the allegations were medically documented, SSA could not establish a period of disability.

### Step 3 -- Index of Disabling Impairments

If an individual has a medically determinable physical or mental impairment documented by medically acceptable clinical and laboratory techniques, and the impairment will meet the duration requirement, the decisionmaker will compare the individual's impairment(s) against an index of severely disabling impairments. The index will describe impairments so severely debilitating that, when documented, can be presumed to equal a loss of functional ability to perform substantial gainful activity without assessing the individual's functional ability. The index will be consistent with the statutory definition of disability by limiting the presumption of inability to perform substantial gainful activity, without considering age, education and previous work, to a relatively small number of claims with the most severe disabilities. Individual functional ability will be assessed in all other cases in a consistent manner at Step 4 in the process.

Because the index will permit severely disabling impairments to be identified quickly and easily, it will only consist of descriptions of specific impairments and the medical findings that are used to substantiate the existence and severity of the particular disease entity. The medical findings in the index will be as nontechnical as possible and will exclude such things as calibration or standardization requirements for specific tests and/or detailed test results (e.g., pulmonary function studies or electrocardiogram tracings). The index will be easy to understand and simple enough so that laypersons will be able to understand what is required to demonstrate a disabling impairment in

the index. Additionally, SSA will draw no conclusions about the effect of an individual's impairments on his or her ability to function merely because an individual's impairment(s) does not meet the criteria in the index. Finally, SSA will no longer need the concept of "medical equivalence" in relation to the index. Because impairments included in the index are presumed to limit functional ability so as to preclude substantial gainful activity without reference to an individual's age, education and previous work, a combination of impairments, or an impairment closely related to one that is in the index, would be found disabling when an individual's functional ability is assessed. Therefore, rules for determining equivalence for impairments in the index will not be necessary.

#### **Step 4 — Ability to Engage in Any Substantial Gainful Activity**

The majority of disability claims will be evaluated using a standardized approach to measuring functional ability to perform substantial gainful activity. This standardized approach will realistically measure an individual's functional ability to do the principal dimensions of work

#### **Standardized Measure of Functional Ability**

SSA will develop, with the assistance of the medical and advocacy community and other outside experts from public and private disability programs, standardized instruments or protocols which can be used to measure an individual's functional ability. These standardized measures of functional ability will be linked to clinical and laboratory findings to the extent that SSA needs to document the existence of a medically determinable impairment or combination of impairments. However, extensive development of all available clinical and laboratory findings will not always be necessary in evaluating an individual's functional ability to perform basic work activities.

Functional assessment instruments will be designed to measure, as objectively

and task performance. The approach will be known and accepted in the medical community. It will be universally used by public and private disability programs in which benefits are based on the ability to perform work-related duties. Standardizing the approach to assessing individual functional ability will facilitate consistent decisions regardless of the professional training of the decisionmakers in the disability process.

In using a standardized approach to measuring functional ability, SSA will be assessing the individual's physical and mental abilities to perform work-related activities. Individualized assessments of functional ability will also consider the effects of the individual's education. Once the individualized assessment of functional ability is made, the individual's age will determine whether his or her functional ability is compared against the demands of the individual's previous work or against a "baseline" of occupational demands. The baseline will describe a range of work-related functions that represent work that exists in significant numbers in the national economy that does not require prior skills or formal job training.

as possible, an individual's abilities to perform a baseline of occupational demands that includes the principal dimensions of work and task performance, including primary physical, psychological, and cognitive processes. Examples of task performance include, but are not limited to: physical capabilities, such as sitting, standing, walking, lifting, pushing, pulling; mental capabilities, such as understanding, carrying out, and remembering simple instructions; using judgment; responding appropriately to supervisors and co-workers in usual work situations; and responding appropriately to changes in the routine work setting; and postural and environmental limitations. To the extent that current regulations already set forth guidelines for evaluating an individual's ability to perform certain of

these tasks, they will be utilized in the new process.

Functional assessment instruments will be designed to realistically assess an individual's abilities to perform a baseline of occupational demands. To the extent possible, objective measures of function will be developed. However, a realistic and individualized assessment of function may require, in addition to objective measures of function, a standardized means or standardized tools for collecting information regarding an individual's perceptions of his or her functioning, the effect of symptoms, including pain, and the individual's activities of daily living. Functional assessment instruments may also require impairment-specific measures to account for the episodic nature of certain impairments or to meet a more general need for longitudinal information.

SSA will be primarily responsible for documenting functional ability using the standardized functional assessments. In the near term, SSA will solicit information on which to base a functional assessment from treating medical sources, other nonmedical sources, and from claimants in a manner that is similar to the current process. In the future, the standardized functional assessments will be widely available and accepted so that functional assessments may be performed by a variety of medical sources, including treating sources. The SSA goal will be to develop

functional assessment instruments that are standardized, that accurately measure an individual's functional abilities and that are universally accepted by the public, the advocacy community, and health care professionals. Ultimately, documenting functional ability will become the routine practice of physicians and other health care professionals, such that a functional assessment with history and descriptive medical findings will become an accepted component of a standard medical report.

Disability insurance payers have incentives to participate in the research necessary to develop standardized functional assessments and some private insurers have already expressed interest in working with SSA in this effort. Standardized functional assessments will not only provide SSA with the functional information necessary to make disability decisions; functional measurements will also assist in developing provider reimbursement levels relating to rehabilitation and in assuring quality in rehabilitation programs by permitting assessment of the relationship between rehabilitative interventions and outcomes. Ultimately, the use of the same functional assessment measurements by both SSA and medical insurance payers will facilitate the cooperation and participation of the medical community in developing, refining, and implementing them.

### **Baseline Occupational Demands**

SSA will use the results of the standardized functional assessment in conjunction with a new standard that SSA will develop to describe basic physical and mental demands of a baseline of work that represents substantial gainful activity and that exists in significant numbers in the national economy.

To develop the new approach, SSA will conduct research and will work in conjunction with outside experts and

consumers to specifically identify the activities that comprise a baseline of occupational demands needed to perform substantial gainful activity. The baseline will describe a range of work-related functions that represent work that exists in significant numbers in the national economy. In establishing the work-related functions that comprise an appropriate baseline of occupational demands, SSA will ensure that: 1) the functional activities are a realistic reflection of the demands of occupations

that exist in significant numbers in the national economy; and 2) the occupations are those that can be performed in the absence of prior skills or formal job training.

The Department of Labor's Advisory Panel for the Dictionary of Occupational Titles (DOT) has made recommendations for developing a new DOT by 1996 which will be a data base system that collects, produces, and maintains accurate, reliable, and valid information on all occupations in the national economy. This new system will provide comprehensive occupational data that includes, but is not limited to: physical

demands of work; sensory/perceptual requirements; cognitive job demands; physical working conditions; and job characteristics such as pace or intensity of work, and the scope of interactions with others. The development of a national data base with detailed occupational information should assist SSA in conducting the initial research necessary to identify a baseline of occupational demands that represents work existing in significant numbers in the national economy. It should also provide a mechanism to ensure that the baseline of occupational demands remains current and reflects changes in the national economy over time.

### Effect of Education

The statute recognizes that education may play a role in an individual's ability to perform substantial gainful activity. Experience demonstrates that educational level alone, i.e., the numerical grade level that an individual has attained, may not be a good indicator of ability to function. For example, completion of a certain educational level in the remote past, without any practical application of that education in recent work activity, has no positive effect on an individual's ability to perform substantial gainful activity. Similarly, completion of a certain grade level does not necessarily represent mastery of the subject matter.

In relying on standardized functional assessments, SSA will be measuring an individual's ability to perform the principal dimensions of work and task performance, including primary physical, psychological, and cognitive processes, and the positive effects of education will

be appropriately reflected in the assessment of an individual's cognitive abilities. Thus, evaluation of a claimant's educational level will be done as an integral part of establishing the functional ability of that individual. The baselining of occupational demands will not reference prior skills or significant formal job training.

The issue of whether literacy and/or specific communication or language skills will be a factor in disability evaluation depends on the extent to which such skills are occupational demands of work existing in significant numbers in the national economy. In conducting the necessary research to identify the occupational demands of baseline work that represents work existing in significant numbers in the national economy, SSA will need to consider whether literacy or specific communication and language skills are required as occupational demands.

### Effect of Age

The effect of aging on the ability to perform substantial gainful work is very difficult to measure, especially in the context of today's world when individuals are living longer than preceding generations. Despite this change, the demographic characteristics of those preceding generations continue

to provide the framework for disability decisionmaking because SSA's approach for deciding disability has changed little since the inception of the DI program.

The statute recognizes that age should be considered in assessing disability on the assumption that the ability to make

a vocational adjustment to work other than work an individual has previously done may become more difficult with age. In determining the impact of age, recognition should be given to the changes that occur with each succeeding generation. Accordingly, in the new process, SSA will establish an age criterion in relation to the full retirement age. The full retirement age will gradually increase over time, based on the recognition that succeeding generations can expect to remain in the workforce for longer periods than the preceding generation.

In applying age criterion under the new process, an individual who falls within

### **Individuals Not Nearing Full Retirement Age**

For an individual who is not nearing full retirement age, SSA will compare the individual's functional abilities against the functional demands of the baseline work. The ability to perform the baseline work will represent a realistic opportunity to perform substantial gainful activity that exists in significant numbers in the national economy and a finding of disability will not be appropriate.

However, anyone who cannot perform the baseline work will be considered unable to engage in substantial gainful activity, and a finding of disability will be justified. The range of work represented

the prescribed number of years preceding the full retirement age will be considered as "nearing full retirement age." In establishing what the prescribed number of years should be, SSA will conduct research and consult with outside experts on the relationship between age and an individual's ability to make vocational adjustments to work other than work the individual has done in the recent past.

SSA will rely on the age of the individual in relation to the full retirement age to decide which of two decision paths to follow as described in the next two sections.

by less than the baseline will be considered so narrow that despite any other favorable factors, such as young age or higher education or training, an individual would not be expected to have a realistic opportunity to perform substantial gainful work in the national economy.

For individuals who are not nearing full retirement age, the ability or inability to perform previous work is not a significant factor. These individuals should be capable of making a vocational adjustment to other work, as long as they are functionally capable of performing the baseline work.

### **Individuals Nearing Full Retirement Age**

For individuals who are nearing full retirement age, SSA will compare the individual's functional abilities against the functional demands of the individual's previous work. Individuals nearing full retirement age can not be expected to make a vocational adjustment to work other than work they have performed in the recent past. However, consistent with the statute, if an individual, even one nearing full retirement age, is capable of performing his or her previous work, SSA will find that the individual is not disabled.

For those individuals who have no previous work, SSA will compare the individual's functional ability to the range of work-related functions that represent work that exists in significant numbers in the national economy, i.e., baseline work, and a finding of not disabled will be appropriate if the individual is capable of performing the baseline work. In such claims, when the fact that the individual has no previous work is not related to the existence of his or her impairment(s), a finding of disability will not be appropriate if the individual retains the functional ability to perform a range of

work-related functions that represent work that exists in significant numbers in the national economy. In contrast, those individuals who have significant functional limitations caused by a medically determinable impairment and

lack of education would not be able to perform a range of work-related functions that represent work existing in significant numbers in the economy. Such individuals would be found disabled, as they are today.

### Medical Consultant Expertise

SSA will continue to rely on medical consultants to provide expert advice and opinion regarding medical questions and issues that will arise in deciding disability claims. Disability adjudicators at all levels of the administrative review process will call on the services of medical consultants to interpret medical evidence, analyze specific medical questions, and provide expert opinions on existence, severity and functional consequences of medically determinable impairments. Additionally, on a national basis, SSA may identify specific types of issues that may require a medical opinion. If a medical consultant is called on to offer expert advice and opinion,

the medical consultant will provide a written analysis of the issues and rationale in support of his or her opinion. The written analysis will be included in the record and will be considered with the other medical evidence of record by disability adjudicators at all levels of administrative review. Additionally, medical consultants will assist in the training of other consultants and disability adjudicators; contact other health care professionals to resolve medical questions on specific claims; carry out public relations and training with the medical community; and participate in the quality assurance program.

### Childhood Disability Methodology

As with adults, SSA must have a structured approach to disability decisionmaking in childhood claims that takes into consideration the relatively large number of claims and still provides a basis for consistent, equitable decisionmaking by adjudicators at all levels of administrative review. The approach for childhood claims must also derive from the statute. Under the statute,

"An individual will be considered to be disabled for purposes of this title if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or

mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months for in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity)." § 1614(a)(3)(A) of the Social Security Act)

Of course, any decision approach for childhood claims must be consistent with the Supreme Court's interpretation of this statutory language in *Sullivan v. Zebley*, 493 U.S. 521 (1990).

### Four-Step Evaluation Process for Children

The disability decision methodology for childhood claims will consist of four steps that are based on the statutory definition of disability. As with adults, the approach is one that provides accurate decisions that can be achieved

efficiently and cost-effectively, primarily by ensuring that documentation requirements are directed toward the ultimate finding of disability. To the extent possible, the approach for childhood claims should mirror the adult

approach. The four steps are:

**Step 1 —** Is the child engaging in substantial gainful activity?  
 If yes, deny.  
 If no, continue to Step 2.

**Step 2 —** Does the child have a medically determinable physical or mental impairment?  
 If no, deny.  
 If yes, continue to Step 3\*.

**Step 3 —** Does the child have an impairment that is included in the Index of Disabling Impairments?  
 If yes, allow\*.  
 If no, continue to Step 4.

**Step 4 —** Does the child have an impairment(s) of comparable severity to an impairment(s) that would prevent an adult from engaging in substantial gainful activity?  
 If yes, allow\*.  
 If no, deny.

*\*An impairment must meet the duration requirement of the statute; a denial is appropriate for any impairment that will not be disabling for 12 months.*

**Step 1 — Engaging in Substantial Gainful Activity**

Any child who is engaging in substantial gainful activity will not be found disabled regardless of the severity of his or her physical or mental impairments. The guidelines for determining whether a child is engaging in substantial gainful activity will be identical to the guidelines for adults. Although the issue of work activity will arise infrequently in childhood claims, the step is warranted for two reasons: 1) the approach for adults and children should be as similar as possible; and 2) as a child approaches age 18, it is increasingly likely that work activity may be an issue.

**Step 2 — Medically Determinable Impairment**

Because the statute requires that disability be the result of a medically determinable physical or mental impairment or combination of impairments, the absence of a medically determinable impairment will justify a finding that a child is not disabled. To establish the presence of a medically determinable impairment or combination of impairments, evidence must show an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

The same guidelines and rules that apply for adults will apply equally for children. SSA will continue to evaluate the existence of a medically determinable impairment based on a weighing of all evidence that is collected, recognizing that neither symptoms nor opinions of treating physicians alone will support a finding of disability.

SSA will use the same exception for evidence collection in childhood claims that will be applied in adult claims. If a child has a medically determinable physical or mental impairment that is not an exception to further development, SSA will then evaluate whether the impairment(s) is included in the index of disabling impairments.

**Step 3 — Index of Disabling Impairments**

If a child has a medically determinable physical or mental impairment or combination of impairments documented by medically acceptable clinical and laboratory techniques and the impairment(s) will meet the duration requirement, SSA will compare the child's impairment(s) against an index of disabling impairments.

As with adults, the index for childhood claims will function to quickly identify severely disabling impairments. The

index will describe impairments so severely debilitating that the impairment is of comparable severity to an impairment that would prevent an adult from engaging in substantial gainful activity without assessing the child's functional ability. As with adults, individual functional ability in childhood claims will be assessed in a consistent manner at Step 4 in the process.

The index for childhood claims will consist of descriptions of specific impairments and the medical findings that are used to substantiate the existence and severity of the particular disease entity. The medical findings in the index will be as nontechnical as possible and will be simple enough so that laypersons will be able to understand what is required to substantiate a disabling impairment in the index. As with adults, SSA will draw no conclusions about the effect of a child's impairments on his or her ability to function merely because a child's impairment(s) is not included in the index. Additionally, SSA will no longer use the concept of "medical equivalence" or functional equivalence in relation to the childhood index.

**Step 4 - Comparable Severity to an Impairment(s) That Would Prevent an Adult From Engaging in Substantial Gainful Activity**

Consistent with the approach for adult claims, SSA will develop, with the assistance of the medical community and educational experts, standardized instruments which can be used to measure a child's functional ability. These standardized measures of functional ability will be linked to clinical and laboratory findings to the extent that SSA needs to document the existence of a medically determinable impairment or combination of impairments. The functional assessment instruments will be designed to measure, as objectively as possible, a child's ability to function independently, appropriately, and effectively in an age-appropriate manner. Ultimately, the course of documenting and developing for functional abilities in childhood claims will, to the extent possible, mirror the adult approach. However, SSA will consider whether it is appropriate to defer the development of standardized functional assessment instruments for use in childhood claims until it gains experience in the development, refinement and use of such instruments for adults.

SSA will use the results of the standardized functional assessments to determine whether a child has impairment(s) of comparable severity to an impairment(s) that would prevent an adult from engaging in substantial gainful activity, as in the current process.

## Medical Evidence Development

### Timely and Accurate Decisions

SSA's ability to provide timely and accurate disability decisions depends to a significant degree on the quality of medical evidence it can obtain and the speed with which it can obtain it. The medical evidence collection process accounts for a considerable portion of the total time involved in processing disability claims.

The new process will eliminate multiple, repetitive requests for information from health care providers. Health care providers will be relieved of requests for information that burden them with far too much paperwork and will be compensated for the time invested in providing information.

### **Core Diagnostic and Functional Information Focus**

The goals of the evidence collection process will be to focus requests for evidence on the critical diagnostic and functional assessment information necessary for a disability decision and to form a new partnership with the sources of this information so that it can be obtained in the most efficient, cost-effective manner. Medical evidence development will be driven by the four-step approach used to decide disability. Two of the core elements of

that approach are: 1) identifying an individual's medically determinable impairments (including those that meet the Index of Disabling Impairments criteria); and 2) assessing the functional consequences of those impairments. The decisionmaker will develop medical evidence that is sufficient to satisfy the core elements but target evidentiary development to obtain only the evidence necessary to reach an accurate decision on the ultimate question of disability.

### **Treating Source Preference**

SSA will give primary emphasis to obtaining medical information from treating sources that provides brief, but specific, diagnostic information regarding an individual's medically determinable impairments and the functional consequences of those impairments. Treating source statements will include diagnostic information about a claimant's impairments, the clinical and laboratory findings which provide the basis for the diagnosis, onset and duration, response to treatment, and the functional limitations that can reasonably be linked

to the clinical and laboratory findings. Depending on the nature and extent of an individual's impairments and treating sources, statements from multiple medical sources may be appropriate. Once the standardized measurement criteria described earlier are widely available, a standardized functional assessment available from a treating source will be accepted as probative evidence. Treating sources or another examining source may perform the standardized functional assessment at SSA's expense.

### **Standardized Request Form**

SSA will develop a standardized form which effectively tailors a request for evidence to the specific diagnostic and functional assessment information necessary to make a disability decision. Such information includes but is not limited to diagnostic information about a claimant's impairments, the clinical and laboratory findings which provide the basis for the diagnosis, onset and duration, response to treatment, and the functional limitations that can reasonably be linked to the clinical and laboratory findings. Treating sources will be encouraged to submit such information electronically. Standardizing requests for evidence in this manner will facilitate the participation of claimants, representatives and third parties in the evidence collection process.

summary form on a single document. In appropriate circumstances, SSA will accept a treating source's statements on the standardized form as to history and diagnosis, the clinical and laboratory findings which provide the basis for the diagnosis, onset and duration, response to treatment, and the functional limitations that can reasonably be linked to the clinical and laboratory findings, without resorting to the traditional, wholesale procurement of actual medical records. In completing standardized forms, treating sources will certify that they have in their possession the medical documentation referred to in the statement and that said documentation will be promptly submitted at the request of SSA. The certification approach does not relieve treating sources from providing objective evidence in support of their diagnoses and opinions; rather it is designed to streamline the collection of necessary evidence. The approach is

The form will permit treating sources to provide necessary diagnostic and functional assessment information in

also consistent with evidence collection methods used by private disability insurance carriers, which request specific medical records in individual claims, when necessary and appropriate to the individual circumstances, or at random as part of a quality assurance program.

Treating source completion of the standardized forms will be monitored to prevent fraud. Decisionmakers will verify

treating source statements by obtaining underlying medical records when appropriate. The automated claim processing system will facilitate effective monitoring of the evidence submission practices of individual treating sources by permitting random and/or targeted selection of claim files involving that treating source for quality assurance and program integrity reviews.

**Treating Source Incentives**

As in the current process, SSA will pay for the reasonable cost of providing existing medical evidence. SSA will acknowledge the value of treating source information by establishing a national fee reimbursement schedule for medical evidence. The fee reimbursement schedule will utilize a sliding-scale mechanism to reward the early submission of medical information; additionally, the sliding scale will be adjusted to reflect the quality of the evidence received. A national, sliding-scale fee schedule will provide incentives for treating sources to cooperate in the evidentiary development process and invest quality time to provide medical certifications on behalf of their patients.

SSA will provide resources to focus professional educational efforts and medical relations outreach at the local and/or regional level to ensure that treating sources are given up-to-date information on program requirements and made aware of specific evidentiary needs or problems as they arise in the adjudication process. SSA will conduct educational outreach on the national level on an ongoing basis with the medical community to provide a better understanding of the SSA disability programs, the medical and functional requirements for eligibility, and the best ways to provide medical information needed for decisionmaking.

**Consultative Examination**

If a claimant has no treating source, or a treating source is unable or unwilling to provide the necessary evidence, or there is conflict in the evidence that can not be resolved through evidence from treating sources, the decisionmaker will refer the claimant for an appropriate consultative examination. Because the standardized measurement criteria for assessing function will be widely available, consulting sources will be able to perform functional assessments that, in the absence of adequate treating source information or where there are unresolved conflicts in the evidence, will be considered probative evidence. Depending on the service area, SSA will consider contracting with large health

care providers to furnish consultative examinations for a specified geographic location.

As part of an ongoing training and medical relations program, SSA will ensure that providers of consultative examinations are provided adequate training on disability requirements. Those medical providers who conduct consultative examinations for SSA will also need ongoing training regarding changes in the disability program. SSA will prepare training programs for this audience which will utilize written, audiotape, videotape, and computerized training methods.

## Administrative Appeals Process

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### Simple, Accessible Process

To eliminate the public perception that multiple, mandatory appeal steps are obstacles to receiving timely, fair, and accurate decisions, SSA will reduce the number of mandatory appeals steps in the administrative process. Streamlining the appeals process will not only promote more timely decisions but also ensure that claimants do not inappropriately withdraw from the claim process based on a perception that it is too difficult or time-consuming to pursue their appeal rights.

Claimants will be able to fully participate in the administrative appeals process with or without a representative. SSA will ensure that claimants are fully advised of their right to representation and SSA will routinely provide the appropriate referral sources for representation. SSA will also encourage the early participation of a representative when the claimant has appointed one and will give the representative responsibility for developing evidence necessary to decide a claim. However, the decision whether to appoint a representative must remain with the claimant and SSA will neither encourage nor discourage claimants in seeking representation.

The administrative appeals process will

instill public confidence in the integrity of the system. To instill such confidence, SSA will provide an initial decisionmaking process that is thorough and results in fully developed records with fair and accurate decisions. Additionally, the claimant will be given the basis of a decision in clear and understandable language. Finally, SSA will ensure that its policies have been consistently applied at all levels of administrative review.

As noted previously, the initial disability determination will use a "statement of the claim" approach which will set forth the issues in the claim, the relevant facts, the evidence considered, including any evidence or information obtained as a result of the predecision notice, and the rationale in support of the determination. The statement of the claim will be part of the on-line claim record and will stand as the basis and rationale for the Agency's action, if the claimant seeks further administrative review. SSA will standardize claim file preparation and assembly, including the use of appropriate electronic records, at all levels of administrative process until such time as the claims record is fully electronic.

### First Appeal Level

Because the initial determination will be the result of a process that ensures fully developed evidentiary records and ample opportunity for the claimant to personally present additional evidence prior to an adverse determination, there

will be no need for any intermediate appeal (e.g., reconsideration) prior to the ALJ hearing. If the claimant disagrees with the initial determination, the claimant may, within 60 days of receiving notice, request an ALJ hearing.

### Adjudication Officer

When a claimant requests an ALJ hearing, an adjudication officer will conduct an interview in person, by telephone, or by videoconference, and become the primary point of contact for the claimant. The adjudication officer will have the same knowledge, skills and abilities as the adjudicators who decide

claims initially. The adjudication officer will also have specialized knowledge regarding hearings procedures. The adjudication officer will be the focal point for all prehearing activities but will work closely with the ALJ, medical consultants and the disability claim manager, when appropriate.

The adjudication officer will provide the claimant an in-depth understanding of the hearing process, with particular focus on the right to representation. To prevent delays caused by a lack of understanding of this right, the adjudication officer will again provide the appropriate referral sources for representation; give the claimant, where appropriate, copies of necessary claim file documents to facilitate the appointment of a representative; and encourage the claimant to decide about the need for and choice of a representative as soon as is practical. The adjudication officer will be available to answer the claimant's questions and concerns regarding the hearing process.

The adjudication officer will also identify the issues in dispute and whether there is a need for additional evidence. If the claimant has a representative, the representative will have the responsibility to develop evidence. If the claimant has a representative, the adjudication officer will also conduct informal conferences with the representative, in person or by telephone, to identify the issues in dispute and prepare written stipulations as to those issues not in dispute. If the claimant submits additional evidence, the adjudication officer may refer the claim for further medical consultation and opinion, as appropriate.

The adjudication officer will have full authority to issue a revised favorable decision if the evidence so warrants. This will ensure that allowance decisions are expedited and not delayed until a formal hearing before an ALJ. If the adjudication officer issues a favorable

decision, the adjudication officer will refer the claim to a disability claim manager to effectuate payment.

The adjudication officer will consult with the ALJ during the course of prehearing activities, as necessary and appropriate to the circumstances in the claim. As a preliminary matter, the adjudication officer will also routinely schedule a date for the hearing that is a standard number of days after the hearing request. Standardizing the hearing date process will facilitate claimant understanding and reduce the possibility of non-appearance at the hearing. It will also enable representatives to plan their schedules when taking on a case. The adjudication officer may exercise discretion in establishing an earlier or later hearing date depending on the individual circumstances and the ALJ's calendar. Electronic access to ALJs' calendars, as established by individual ALJs, will facilitate timely and appropriate scheduling of hearings. The adjudication officer will refer the prepared record to an ALJ only after all evidentiary development is complete and the claimant or a representative agrees that the claim is ready to be heard.

The ALJ will retain the authority and ability to develop the record. However, use of an adjudication officer realigns most, if not all, prehearing activities so that the burden of ensuring their completion rests with other members of the adjudicative team. With completely developed claims before them, ALJs will be able to concentrate their efforts on conducting more hearings and rendering decisions faster.

## Hearing Proceedings

The ALJ hearing will be a de novo proceeding in which the ALJ considers and weighs the evidence and reaches a new decision. A de novo hearing is consistent with the role of an ALJ envisioned under the Administrative Procedure Act. Under that scheme, the ALJ is an independent decisionmaker who must apply an agency's governing

statute, regulations and policies, but who is not subject to advance direction and control by the agency with respect to the decisional outcome in any individual claim. ALJs are independent triers of fact who perform their evidentiary factfinding function free from agency influence. At the same time, the Administrative Procedure Act ensures

that an ALJ's decision is subject to later review by the agency, thus giving the agency full authority over policy. Policy responsibility remains exclusively with the agency while the public has assurance that the facts are found by an official who is not subject to agency influence.

A hearing before an ALJ will remain an informal adjudicatory proceeding as it is under the current process. The claimant will have the right to be represented by an attorney or a non-attorney with the decision regarding representation made by the claimant alone. An informal, nonadversarial proceeding is consistent with the public's strong preference for a simple, accessible hearing process that permits, but does not require, a representative. An informal process facilitates the earlier and faster resolution of the issues in dispute, thus promoting more timely decisions.

As an independent factfinder in a nonadversarial proceeding, the ALJ will still have a role in protecting both SSA interests and the claimant's interests, particularly when the claimant is unrepresented. However, an improved initial determination process with its focus on early and comprehensive evidentiary development, predecision notices and opportunity for personal

interviews, fully rationalized initial decisions, and prehearing analysis of contested issues should ensure that the Agency position is fully explored and presented to the ALJ. Moreover, the primary burden of compiling an evidentiary record will be shifted to the representative—if one is appointed—or to the claimant (when able to do so), with assistance (when necessary) from SSA personnel. This will permit the ALJ, in most circumstances, to close the record at the conclusion of the oral hearing, deliberate on the issues, and render prompt decisions.

In making disability decisions, ALJs will rely on the same standards for decisionmaking that are used by the disability claim managers and adjudication officers. Adjudication officers and other decision writers will assist ALJs in preparing hearing decisions, using the same decision support system that supports the preparation of initial disability determinations. A simplified disability decisional methodology, in conjunction with the use of prehearing stipulations that frame the issues in dispute, will result in shorter, more focused hearing decisions. If the ALJ issues a favorable decision, he or she will refer the claim to a disability claim manager to effectuate payment.

### **Final Decision of the Secretary**

Under the new process, if a claimant is dissatisfied with the ALJ's decision, the claimant's next level of appeal will be to Federal district court. A claimant's request for Appeals Council review will no longer be a prerequisite to seeking judicial review.

As under the current process, the Appeals Council will continue to have a role in ensuring that claims subject to judicial review have properly prepared records and that the Federal courts only consider claims where appellate review is warranted. Accordingly, the Appeals Council, working with Agency counsel, will evaluate all claims in which a civil

action has been filed and decide, within a fixed time limit whether it wishes to defend the ALJ's decision as the final decision of the Secretary. If the Appeals Council reviews a claim on its own motion, it will seek voluntary remand from the court for the purpose of affirming, reversing or remanding the ALJ's decision. The Secretary's authority for seeking voluntary remand prior to the Secretary's filing of an answer to the civil action is currently provided for in § 205(g) of the Act. Favorable Appeals Council decisions will be returned to the disability claim manager to effectuate payment. The number of civil actions requiring substantive action by the

Appeals Council will be relatively small because, in the new process, ALJ decisions will be the result of a fully developed evidentiary record where the factual and legal issues have been focused for final resolution.

Council decides to review a claim on its own motion, the Appeals Council may affirm, reverse or remand the ALJ's decision, or vacate the dismissal. The Appeals Council's review will be limited to the record that was before the ALJ.

Additionally, the Appeals Council will have a role in a comprehensive quality assurance system. As part of the in-line review component of this system, which is described in greater detail below, the Appeals Council will conduct own motion reviews of ALJ decisions (both allowances and denials) and dismissals prior to effectuation. If the Appeals

The Agency will establish appropriate mechanisms to respond to claimant allegations of ALJ misconduct or bias. To the extent that the allegations of ALJ misconduct may affect the final decision in a claim, the Agency will consider whether an appropriate mechanism includes some form of final Agency review at the claimant's request.

## Quality Assurance

### System of Agency Accountability

SSA will be accountable to the public, the ultimate judge of the quality of SSA service, and will strive to consistently meet or exceed the public's expectations. SSA will have a comprehensive quality assurance program that defines its quality standards, continually communicates them to employees in a clear and consistent manner, and provides employees with the means to achieve them.

The quality assurance program will have three primary components: 1) substantial resources to ensure that the right decision is made the first time; 2) comprehensive and systematic reviews of the quality of the decisionmaking process at all levels; and 3) measures of customer satisfaction against the SSA standards for service.

### Investment in Employees

SSA's ability to ensure that the right decision is made the first time depends on a well-trained, skilled, and highly motivated workforce that has the program tools and technological support to issue quality decisions.

training programs will also address changes to program policy. Consistent program policy training will be provided to disability decisionmakers at all levels of the process.

SSA will make an investment in comprehensive employee training to ensure that all employees have the necessary knowledge and skills to perform the duties of their positions. SSA will develop national training programs for initial job training and orientation as well as continuing education to maintain job knowledge and skills. Such training will include general communication skills and how to deal effectively with the public generally, and disability claimants in particular. National

In addition to initial program training, continuing education opportunities will be made available to employees to enhance current performance or career development. These opportunities may be in the form of self-help instruction packages, videotapes, satellite broadcasts, or non-SSA training or educational opportunities. SSA will ensure that employees are given sufficient time and opportunity to complete the required continuing education. Employee feedback on the value of these continuing education

opportunities, including the quality of training materials, methods, and instructors, will be used to continually improve training programs.

In addition to formal program training, SSA will rely on a targeted system of in-line quality reviews and monitoring of adjudicative practices for all employees. The elements include a mentoring process for new employees, peer review for experienced employees and management oversight at key points in the adjudicative process. SSA will create mechanisms that facilitate peer discussions of difficult claims or issues. Quality reviewers and policy makers will participate in these types of discussions. Peer reviews and mentoring will not only promote timely and accurate development of disability claims, but will also foster a spirit of teamwork. They will also promote earlier identification and resolution of problems with policy or procedures. Managers will be expected to oversee the adjudication process. They will conduct spot checks at key points in the adjudication process or perform special reviews based on profiles of error-prone claims. The goal of these reviews is to provide immediate, constructive feedback on identified errors to reduce or eliminate their possible recurrence. Payment errors on claims detected during in-line reviews will be corrected before a claimant is notified of the decision.

As noted previously, under the Administrative Procedure Act, the ALJ is an independent decisionmaker who must apply an agency's governing statute, regulations and policies, but who is not subject to advance direction and control by the agency with respect to the decisional outcome in any individual claim. Accordingly, a system of peer review, mentoring and management oversight in advance of the ALJ's decisionmaking is inappropriate. However, the ALJ decision may be

subject to final agency review. Therefore, as part of the in-line quality assurance process, ALJ decisions (both allowances and denials) and dismissals will be subject to review by the Appeals Council on its own motion prior to effectuation of the ALJ's decision or dismissal.

Several key features previously described in this plan are critical to ensuring that adjudicators have the necessary program tools to issue accurate decisions. A single presentation of all substantive policies used in determining eligibility for benefits must be in place. Additionally, an automated and integrated claim processing system will provide the necessary technological support for adjudicators at all levels of the administrative process. Expert systems will be developed to integrate disability policy into the claim processing system. Among other things, the claim processing system will facilitate claims taking, evidence development, and the preparation of accurate notices and decisions by providing on-line editing capacity to identify errors in advance and decision support software to assist in analysis and decisionmaking. The processing system will help to identify errors of both procedure and substance, and also support routine analysis to aid in avoiding future similar errors. An on-line technical review will occur each time information is added to the electronic record.

Comprehensive employee education and an in-line review system will build quality into the system of adjudication with the goal of error prevention. SSA must monitor that quality on a systematic, national basis. Accordingly, all employees (including ALJs) will be subject to and receive continuous feedback from comprehensive end-of-line reviews as described in the following section.

## End-of-Line Reviews

A second necessary component of quality assurance is an integrated system of national postadjudicative monitoring to ensure the integrity of the administrative process and to promote national uniformity in the adjudication of disability claims at all levels of the process. This system of quality measurement will include comprehensive reviews of the whole adjudicatory process. At a minimum, a comprehensive end-of-line quality measurement system must: be statistically valid; review both allowances and denials in equal proportion; review the entire disability claim process, both the medical and nonmedical aspects; and review claims decided at all levels of the adjudicatory process.

These end-of-line reviews will focus on whether correct decisions were made at the earliest possible point in the process. This type of review will not be aimed at correcting errors in individual claims but, rather, will be the means to oversee, monitor and provide feedback on the application of Agency policies at all

levels of decisionmaking. However, erroneous decisions detected during end-of-line reviews will be subject to existing reopening regulations. Reliance on an integrated claim processing system will facilitate the selection of a statistically valid sample of claims at all levels of the process for this review.

An integrated claim processing system will permit the selection of other postadjudicative samples of claims as SSA deems necessary to effectively test new operational procedures or monitor specific procedures in the administrative process; oversee the implementation of new program policy regulations and initiatives; and monitor both internal and external claims development practices to prevent fraud.

SSA will use the results from these end-of-line reviews to identify areas for improvement in policies, processes or employee education and training. SSA will also use the results to profile error-prone claims with the goal of preventing errors at the front end.

## Customer Satisfaction Surveys

A final component of quality assurance is measuring customer satisfaction. To measure whether SSA has met or exceeded the public's service expectations, SSA must measure the public's level of satisfaction with the level of service SSA provides. Customer surveys (including feedback cards) and periodic focus groups will be the most frequently used methods of determining the public's views on the quality of SSA service. SSA will also survey representatives and third parties who provide assistance or act on claimants' behalf in dealing with SSA. Survey results will be communicated to staff on

a timely basis, both as Agency feedback and individual feedback, along with any plans to address identified problems.

SSA will also seek employee feedback on how well SSA has met their expectations. Employee feedback will be sought on a wide array of issues including Agency goals and performance indicators, training and mentoring needs, and the quality of operating instructions. Although formal mechanisms will be used to obtain feedback periodically, each employee will be encouraged to provide continuous feedback on how to make improvements in the process.

## Measurements and Management Information

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### Service Perspective

SSA's measures of performances will be revised to assess the performance of the Agency as a whole in providing service to claimants for disability benefits. Management information regarding the contributions at each step in the process to the final product, as well as to the work product passed on to other steps will be available. For example, current component processing time measures will be replaced by a measure of time from the first point of contact with SSA until final claimant notification. Meaningful, timely management information will be facilitated by a seamless claim processing system with a common database that is used by all individuals who contribute to each step in the process.

Other measures, such as cost, productivity, pending workload, and accuracy will be developed or revised to assess the performance of the Agency as a whole and the participants in the process who contribute to this performance. Measurements for public

awareness, as well as claimant and employee satisfaction, will add to this assessment.

Management information will be current and accessible from an intelligent workstation. In addition to routine, published national reports generated from the management information system, other reports needed by national or local entities, or individual employees will be preformatted and system-generated on demand. Managers and employees will have the flexibility to change parameters and to access the full data base, permitting comparisons of performance and trends analysis. The management information system will also permit customized, ad hoc reports for special studies or immediate special purpose activities with access to the full data base. Tools including user-friendly report generator software and statistical forecasting and modeling applications will be available on the intelligent workstation to assist users in the data analysis.

## New Process Enablers

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Reengineering is dependent on a number of key factors that provide the framework for the new process design.

Each of these "enablers" is an essential element in the new disability process.

### Process Unification

Under the Social Security Act, the Secretary is granted broad authority to promulgate regulations to govern the disability determination process. In addition to regulations, SSA publishes: 1) Social Security Rulings, which are precedential court decisions and policy statements or interpretations that SSA has adopted as binding policy, and 2) Acquiescence Rulings, which explain how a decision by a U.S. Court of Appeals will be applied when the court's holding is at variance with the Agency's interpretation of a provision of the statute or regulations. ALJs and the

Appeals Council rely on the regulations and rulings in making disability decisions. However, guidance for decisionmakers at the initial and reconsideration levels is provided in a series of administrative publications, including: 1) the Program Operations Manual System instructions which provide the substance of the statute, regulations, and rulings in a structured format and 2) other administrative issuances which clarify or elaborate specific policy issues. The use of different source documents by adjudicators fosters the perception that different policy standards are being

applied at different levels of decisionmaking in the disability claim process.

To ensure that SSA provides consistent direction to all adjudicators regarding the standards for decisionmaking, SSA will

develop a single presentation of all substantive policies used in the determination of eligibility for benefits. These policies will be published in accordance with the Administrative Procedures Act and all decisionmakers will be bound by these same policies.

**Public and Professional Education**

Public and professional education is essential to ensure that individuals and other groups involved in the disability process have a proper understanding of SSA disability programs, their medical and nonmedical requirements, and the nature of the decisionmaking process.

SSA will make information widely available for the general population with the goal of reducing general inquiries from members of the public unfamiliar with SSA disability programs and increasing the number of claimants who enter the disability process knowledgeable and prepared to assume responsibility for pursuing their claims. Pamphlets, factsheets, posters, videos, information on diskettes and on computer bulletin board systems will be developed and presented in a simple, straightforward and understandable manner. Information will be available in many languages and dialects and will accommodate vision and hearing impaired individuals.

SSA will work with national and local groups involved in the disability programs to develop direct lines of communications. These efforts will be aimed not only at providing information but also at creating ongoing organizational relationships to maintain a dialogue about the disability process.

SSA will also conduct educational outreach with the medical community to provide them with a better understanding of the SSA disability programs, the medical and functional requirements for eligibility, and the best ways to provide medical information needed for decisionmaking. In addition to the use of printed materials, SSA will arrange briefings and training sessions in association with medical organizations and societies at the local, State and national levels, as well as through hospital staff meetings. Those medical providers who conduct consultative examinations for SSA will need ongoing training regarding changes in the disability program. SSA will prepare training programs for this audience which will utilize written, audiotape, videotape, and computerized training methods.

SSA will conduct outreach efforts with the legal community, to ensure that information about the disability programs is widely available to the organized bar and the Federal judiciary. Policy documents, regularly updated electronically, and rules of representation will be available at forums sponsored by the organized bar and in initial orientation and continuing legal education programs designed for Federal judges.

**Claimant Partnership**

SSA's interaction with claimants will focus on enabling their participation in the process. SSA will also work with third parties, such as family members and community-based organizations, to provide additional claimant support.

Understandable public information

materials and comprehensive information packets will be widely available. Explanations of the programs, the decisionmaking process, and claimant responsibilities will be widely available and furnished at the point individuals first make contact with SSA. Claimants, who are able to do so, will be asked to

do more to facilitate development of supporting information, particularly with respect to medical evidence. To encourage the release of evidence by treating medical sources, SSA will network with the treating source community to overcome the lack of understanding and possible resistance to providing patient information. SSA will encourage private insurers and public agencies that refer claimants to SSA as a condition of receiving other benefits to provide medical evidence for these individuals.

SSA will develop ongoing relationships with community organizations to ensure that competent third-party resources are available to assist the claimants. Examples of resources that SSA will help develop include: transportation and escort services for indigent claimants and those who experience difficulty in getting to consultative examinations; enhancement of medical provider capacity to identify potentially eligible patients, secure claims and provide medical evidence; and software with compatible format design which will allow direct input of claim-related information to SSA. SSA will have an ongoing demonstration program that provides funds for truly innovative

projects that test models for national implementation.

In order to expedite the referral of potentially eligible individuals, SSA will develop productive working relationships with Federal, State and local programs that serve individuals with disabilities. Other programs will be able to use SSA-developed decisional support systems to evaluate potentially eligible persons prior to referral and to transfer information to SSA through compatible databases. Local managers will be encouraged to develop and maintain appropriate working relationships with local Federal, State and third-party resources.

Active participation by claimants, supported by SSA's efforts and the contributions of third parties will result in a fundamental shift in claimant expectations and satisfaction with the SSA disability process. From the SSA perspective, the results will be better service to customers through timely, fully supported decisions rendered at all decisional levels; better use of SSA resources focused on helping those who need assistance; and greater public confidence in the disability adjudication process.

## **Workforce Maximization**

Teamwork and workforce empowerment are fundamental ingredients in the new process. In carrying out their duties and responsibilities, adjudicators will work in a team environment with internal medical and nonmedical experts, who provide advice and assistance for complex case adjudication, as well as with technical and other clerical personnel who may handle more routine aspects of case development and payment effectuation. The disability claim manager will be the focal point at the initial claim level, assisted by technical and medical support staff. The adjudication officer will be the focal point at the prehearing level, relying on technical and medical support staff, as well as interacting with the disability

claim manager and the ALJ, as necessary. The ALJ will be the focal point at the hearing level, receiving support from technical and medical support staff, and also interacting with the adjudication officer and disability claim manager, as necessary.

Each team member will have at least a basic familiarity with all the steps in the process and an understanding of how he/she complements another's efforts. Team members will be knowledgeable but will also be able to draw upon each other's expertise on complex issues. Communication among team members will encourage consistent application of disability policy. Improved automated systems will enable members of the

team to work together using a shared data base even when they are not co-located. Handoffs, rework, and non-value steps will be significantly reduced and fewer employees will be involved in shepherding each claim through the process.

Employees will perform multiple tasks instead of singular activities, thus their roles will expand to encompass more of the "whole" job. This will enable employees to experience the direct relationship between their actions and the final product. Adequate resources and sufficient training and mentoring will allow employees to acquire the skills they need to process claims from intake

through adjudication. Employees will feel more of a sense of ownership for the services they perform as a member of a team focused on serving claimants.

The new process will rely heavily on increased employee empowerment, applying information technology and using professional judgment to complete tasks more effectively and efficiently without constant checking, direction and micro-management. Recognition and reward processes will be revised to emphasize contributions to team outcomes and acquisition of knowledge bases. Continuous quality improvement activities will foster ongoing incremental process change.

**Representatives:  
New Rules and  
Standards of  
Conduct**

The Social Security Act and regulations have long recognized the representational rights of claimants and have provided an administrative framework designed to ensure that claimants will have access to the legal community and others in the pursuit of their claims. Representatives currently have the option for authorization of fees through two procedures: 1) the fee petition method, whereby the representative presents an itemization of services rendered and time expended, and SSA determines a reasonable fee; and 2) the fee agreement method, whereby the claimant and representative agree to a fee of 25 percent of the retroactive benefits due or \$4,000, whichever is less.

Focus groups of claimants and the general public have indicated that the disability program is too complex to understand and the process too fragmented and difficult for them to navigate alone. While many claimants resent having to pay a representative to establish entitlement to government-sponsored benefits, they feel that they have no choice if they want to be successful in this pursuit. Although the current regulations provide protection for claimants from fee abuses, these rules fall short of assuring

claimants that the representatives they retain are qualified and will adequately represent their interests.

In the new process, SSA will continue to have a responsibility for monitoring representational activity and for safeguarding the interests of claimants. The new process will establish rules of representation and standards of conduct to ensure that representatives fulfill their responsibilities and serve the needs of the claimants they represent. These new rules will, among other things, ensure that claimants receive competent representation; establish a code of professional conduct for representatives in all matters before SSA; and provide sanctions against representatives, including suspension and disqualification from appearing before the Agency in a representative capacity, for violating the rules of representation and standards of conduct. Without disturbing the statutory intent of facilitating claimant access to representatives, the simplified and user-friendly new process may well result in more claimants pursuing their claims without representation. However, the issue of representation will remain a matter of a claimant's personal choice. The new rules and standards of conduct provide the framework for assuring that representatives claimants retain will be

qualified, will have the obligation to fully develop the record on their behalf, will adequately represent their interests, and will be accountable for misconduct or dereliction of duty.

SSA will also conduct outreach efforts with the legal community, to ensure that information about the disability programs

is widely available to the organized bar and the Federal judiciary. Policy documents, regularly updated electronically, and rules of representation will be available at forums sponsored by the organized bar and in initial orientation and continuing legal education programs designed for Federal judges.

## Information Technology

Information technology will be a vital element in the new disability claim process. To the fullest extent possible, SSA will take advantage of the "Information Highway" and those technological advances that can improve the disability process and help provide world-class service. The new process will rely on seamless, electronic processing of disability claims from the first contact with the claimant to the final decision, including all levels of administrative appeal. Existing Agency design plans for Intelligent Workstation/Local Area Network (IWS/LAN) and a Modernized Disability System will provide an integrated system and the electronic connectivity necessary to support the new disability process.

In a seamless electronic environment, all employees will use the same hardware, the same claim assignment and scheduling software, the same decision support software, the same case control system, the same fiscal and accounting software, the same integrated quality assurance functionality, and the same management information system throughout all stages of the process. In this environment, data will need to be input and validated once and multiple employees may access a single claim record simultaneously.

Information technology will be applied to enhance access to services by claimants, their representatives, and other third parties. Claimants will be able to conduct business with SSA via telephone, self-help workstations, kiosks, videoconferencing, and electronic data transfer at SSA facilities and other

satellite locations. SSA will conduct forums and produce video and computer-based training materials for third parties who wish to participate in assisting claimants to file applications and gather medical evidence. Wherever possible, physicians and health care organizations, advocates, community counseling services, and other professionals who regularly provide assistance to SSA claimants will be supplied with SSA software to electronically complete Agency forms. Data will be transferred to SSA using agreed upon methods. SSA will allow authorized representatives appropriate access to electronic claim folders. Paper versions of treating source forms will be designed so that the data can be read by scanning equipment into SSA claim processing systems. A single vendor payment system will be used to pay certain evidence providers for information which they provide SSA. To further paperless processing, SSA will adopt a "signature on file" policy for the claimant's evidence release authorization to eliminate routing of paper medical release forms.

The ability of decisionmakers to conduct thorough interviews and evidence evaluation, and timely and accurate claim adjudication is predicated on the implementation of the functionality provided by the IWS/LAN hardware and software components, and the decision support features of the Modernized Disability System. Expert system software will be included in SSA claim processing systems to assist disability decisionmakers in the analysis and evaluation of complex eligibility factors,

and to ensure that the correct procedures for disability evaluation are followed. While conducting interviews, disability decisionmakers will rely on decision support features that ask impairment-specific questions. The decision support system will use the accumulated data of the electronic record to assist in the preparation of the predecision notice, the statement of the claim, and decisions rendered on appeal. Where disability decision team members cannot be physically co-located, they can remain in communication by using two-way TV and other videoconferencing technologies. Disability policy will be developed and stored in a format that can be integrated into computer systems as the source of context-sensitive help screens and decision-support messages.

Quality assurance features fully supported by the Modernized Disability System will be integrated throughout the new process. For example, the national end-of-line quality review sample will be

electronically selected and automatically routed to appropriate staff. In-line programmatic quality assurance, enhanced by the use of decision support systems, will be programmed into the computer applications and will help to identify errors of both oversight and substance, and also support routine analysis to aid in avoiding future similar errors. An on-line technical review will occur each time information is added to the electronic record.

Quality assurance and productivity measures will be incorporated in a new, total process management information system. Meaningful, timely management information for the disability process is dependent on a seamless data processing system used by all components which affords a common case control system and a common data base. SSA's claim processing systems integrated on an Agency-wide (WS/LAN) platform will provide this seamless environment.

# COST AND BENEFITS

## Introduction

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SSA's strategy of coming to closure on an ideal, high-level disability process design before undertaking detailed operational and implementation planning has been consistent from the beginning of the reengineering project. Although this project management approach served SSA well, it has made the very necessary task of cost/benefit projections unusually challenging. The following cost/benefit forecasts will need to evolve as implementation details are developed. The administrative cost numbers presented here cannot be applied to SSA's administrative budget without further analysis.

SSA will move forward on all aspects of the process redesign plan; however, because of the extensive research and development required for implementation of the simplified disability determination methodology, we have not considered the effect of this redesign feature in our cost/benefit planning. In addition, because the ability of a single employee to master the disability claim manager position is dependent on full adoption of a simplified disability determination methodology, the impact from that process redesign feature has also been separated out from our cost/benefit planning at this time.

## Service Improvements

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Service to the public, as defined by average processing time, would improve dramatically--from around 150 days to pay an initial disability claim today to 60 days after implementation of the new

process. Hearing processing time would also improve from about 550 days to 225 days. These figures were derived from running a computer simulation model of the new process.

## Program Costs

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Under the supposition that SSA's current initial claim and administrative appeal process leads to correct disability determinations within the proper universe of people today, and

because SSA is not proposing any changes in the statutory definition of disability, the redesigned process in and of itself would have no long-term effect on program outlays.

## Administrative Costs and Savings

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The project life period for implementing disability reengineering is from October 1, 1994 to September 30, 2000. However, the full benefits from the redesigned process will not be realized until September 30, 2001.

Cumulative administrative costs during the life of the project are estimated at

\$148 million. The largest percentage of these costs will be directed to special workforce training on the new process--a critical enabler if the redesign plan is to work. The redesign will not require additional investments in information technology spending over current SSA plans.

Cumulative administrative savings through FY 2001 are estimated at \$852 million. The bulk of these savings will come from more efficient use of Federal and State workyears to process the anticipated disability initial claim and appeal workloads during the project life period. This savings estimate does not factor in Agency resource needs for working existing backlogged disability cases.

Subtracting cumulative administrative costs of \$148 million from cumulative savings of \$852 million will result in a pay back to the government of \$704 million through FY 2001.

Ongoing administrative cost savings will be over \$305 million annually, beginning in FY 2001. This figure includes spending increases for enhanced

employee education, better office security, and expanded claimant services.

The administrative cost savings associated with this project--\$704 million during the implementation period, and \$305 million annually, thereafter--will allow the Agency to reallocate existing resources to give more attention to other important workloads.

SSA's workforce profile, with respect to disability process workloads, would include at least the same number of professional positions currently employed at the federal and state level. However, the overall design, if fully implemented with all the process enablers--especially enhanced automation--would require fewer clerical and support positions to handle projected workloads.

## Conclusion

SSA is committed to implementing a new disability determination process that will deliver significantly improved service to the public, remain neutral with respect to program dollar outlays, and will be more efficient to administer.

Administrative cost savings from the process will allow the Agency to reallocate resources to give increased attention to other important workloads.

However, the redesigned process cannot

be implemented without the full funding, development, and installation of a new case processing computer system. In addition, unless SSA invests substantially more funds for research and development of the simplified disability determination methodology, the full benefits of the redesigned process--including better public service and the potential for even greater long-term administrative efficiencies--will not be possible.

# IMPLEMENTATION STRATEGY

## Overview

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The disability process redesign is a high-level process description that provides a broad vision of how a new process would work but leaves operational, organizational, and other details for later development and implementation. SSA must now begin to transition from the high-level analysis into this latter phase. As SSA implements the new process, the five objectives of the redesign effort must continually be kept in the forefront of implementation planning, execution and assessment: the process will be user-friendly for claimants and those who assist them; the right decision will be made the first time; decisions will be

made and effectuated quickly; the process will be efficient; and the new process will provide employees with a satisfying work environment. The success of the new process must be measured against these objectives and emphasis must continually be on overall measurement from the customer's perspective, and not individual component results. Implementing a process of the magnitude of the new disability claim process will require a strategy that is comprehensive, creative, and inclusive. The following provides a general framework for how implementation activity will proceed.

## Implementation Framework

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### Multiple Track Approach

Planning for the implementation of the new process vision requires a comprehensive approach that moves forward on multiple fronts simultaneously. Although the new process will not be fully implemented until FY 2001, SSA must start on October 1, 1994 (the beginning of FY 1995), to initiate activities, changes and improvements that will establish the plan and pace for the long-term full implementation of the new process. The goal is to make near-term, visible improvements while at the same time building for long-term results.

Immediate or near-term implementation activities are those that can begin in FY 1995 and will be fully implemented nationwide by the end of FY 1996, or for which the research and development or site testing can be initiated within the next two fiscal years. These activities include streamlining and simplification initiatives or other procedural elements of the new process that can be

implemented using existing administrative or regulatory discretion. They also include client-service activities associated with improving the claimant's access and entry into the disability claim process; the development and site testing of options for streamlining parts of the administrative appeals process; the provision of consistent training and direction to disability decisionmakers; and the establishment of new measures and the testing of new quality assurance mechanisms. Additionally, because the decision methodology associated with the new process depends on significant amounts of research, consultation, development and refinement, SSA must identify the specific research needs, develop the appropriate scope of work and award research contracts as near-term activities.

Long-range implementation items are those requiring extensive research and development that could not be tested fully before FY 1999 or could not be

fully implemented nationwide before FY 2001. These activities are those associated with the full development, testing and refinement of a new decision methodology. They also include the implementation of advanced technology enhancements that provide a single, fully-integrated disability claim processing system which supports paperless claim processing and provides interactive capabilities for claimants and those who assist them, and for providers of evidentiary information.

The remaining mid-term items or

activities are those elements of the new process that can be developed and tested in FYs 1997 and 1998 and/or fully implemented nationwide by FY 1998. Mid-term activities would include such items as the phased testing and implementation of new service options; full development, testing and implementation of a streamlined appeals process; the testing of more advanced technology enhancements; and the activities associated with developing the decision methodology based on the results of research efforts completed by the end of the near term.

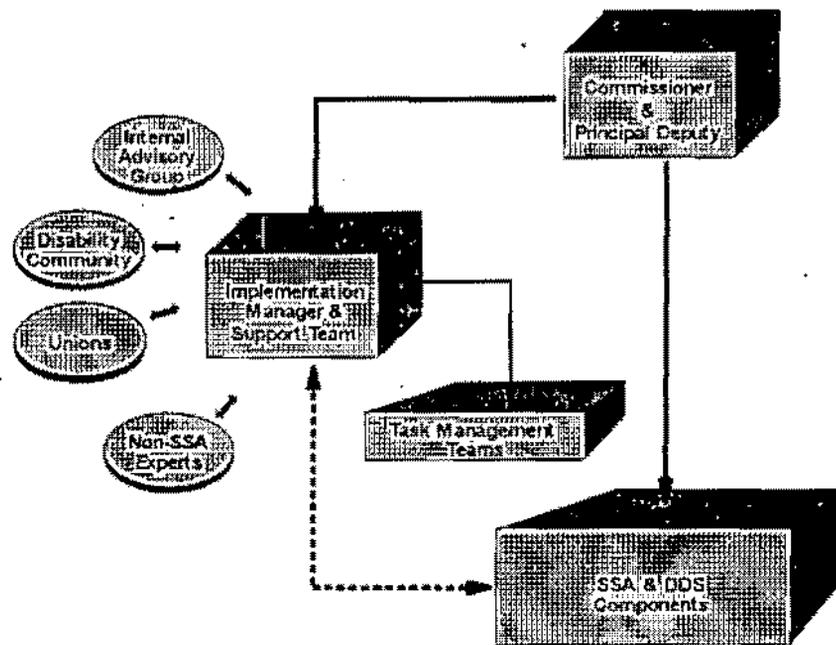
### Flexibility and Testing

SSA recognizes that full implementation of the new process vision is an iterative process that requires development, testing, additional information gathering and possible modification of process changes as they are implemented. Although SSA is committed to moving forward quickly to begin implementing the new process, SSA has embraced an equally strong commitment to rigorous testing and refinement of process changes before they are fully or permanently implemented. Testing may include, but is not limited to, geographic or time-limited site testing, using "laboratory" settings, or relying on specific case studies. Formalized testing is most appropriate for process changes that depend on longer-term research and development, phased implementation or major organizational change. In selecting sites for initial implementation activity, SSA will take advantage of the interest

and capability of different offices, states, or regions to demonstrate the viability of immediate improvements or identify early successes in improved service or efficiency. Implementation sites will, of course, be provided with the necessary resources to support their efforts.

Even with extensive testing, the nature of public policy formulation, as well as sound management principles, dictate that SSA remain flexible in developing, refining and implementing the specific elements of the new process vision. Ultimately, if the results of the iterative process necessitate modifications to the process vision, SSA is prepared to make those modifications. SSA is committed to change, not for its own sake, but because it is necessary to meet present and future challenges as it strives to provide high-quality, responsive, world-class service to its customers.

## Implementation Strategy



### Employees Will Make Change Happen

Overall leadership, control, and coordination of all implementation activities are vested in the Implementation Manager, who will report to the Commissioner and Principal Deputy Commissioner. As part of these responsibilities, the Implementation Manager, with the assistance of a support team, will establish implementation priorities, develop specific timelines, and provide oversight to ensure that implementation decisions are consistent with the new process visions and the five process objectives.

Although the Implementation Manager will be the focal point for all implementation activities, it is the employees and organizational components in the SSA and DDS communities who will make the new disability claim process a reality. Front-line employees will be asked to directly participate in the development, testing and implementation of process changes. They will also provide feedback on the

effectiveness of these changes. Task management teams will be chartered to address specific implementation issues and their duration will depend on the nature of their issue. For example, task teams that might be expected to require a longer-term existence are those dealing with decision methodology or organizational readiness and change management. The task teams will bring together staff from the affected SSA and DDS components to provide the necessary guidance for actual implementation by organizational components. Central office components, working with their Regional office counterparts, will be responsible for ensuring that necessary implementation actions are effectuated.

SSA will rely on an internal Advisory Group, comprised of SSA executives and union and association leaders, to provide advice and guidance on implementation activities and facilitate communication about implementation plans.

**Non-SSA  
Experts and  
Interested  
Parties**

SSA will use an inclusive process that seeks input from a variety of non-SSA communities including, but not limited to, disability advocates, physicians, other health care and rehabilitation providers, and the private disability and

health insurers. The goal of this inclusive process is to foster creative relationships with non-SSA experts so that SSA can have access to specialized expertise and advice as implementation activities progress.

**Open Lines of  
Communication**

SSA's unprecedented effort to establish new and beneficial communication channels during the various phases of the disability claim process redesign lays the groundwork for continued communication during implementation. The internal and external contacts and the avenues of communication established during the public dialogue period will continue and will be an integral part of the implementation process. SSA will continue open lines of communication about implementation of the new process with individuals and organizations who have a stake in the disability process, including front-line

employees, representatives from Federal and State employee unions and associations, other Federal agencies, the Congress, the judiciary, and disability advocates. SSA will use all appropriate avenues of communication, including written materials, telecommunications, and personal briefings, to ensure that necessary information about implementation activities is regularly and widely disseminated and to develop appropriate feedback channels. Additionally, SSA will explore new opportunities and means of communicating with both internal and external audiences to permit meaningful exchanges of information.

# APPENDIX I: METHODOLOGY

## Business Process Reengineering

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The Process Reengineering Program is the culmination of a rigorous SSA investigation of the reengineering efforts and methodologies of those companies, public organizations, academic institutions, and consulting firms with the most "hands on" experience in this field. The positive findings from this detailed review, combined with concerns about existing business processes within SSA and the quality of SSA service to the public, led management to the conclusion that a process reengineering effort was critical to the SSA objective of providing "world-class" administration and service.

Based largely on analysis of what has worked best in the private and public sectors, a customized reengineering methodology was developed within SSA. It uses a reengineering team approach that combines a strong "customer" focus with classic management analysis techniques, and computer modeling and simulation, to intensely review a single business process. The objective is not to make small, incremental improvements in the various pieces of the process, but to redesign it as a whole, from start to finish, so that it becomes many times more efficient and, in so doing, significantly improves SSA service to the public.

A senior SSA manager was selected to

serve as Director of the Process Reengineering Program. The Director leads all SSA process reengineering efforts, is the primary liaison with the Commissioner and Executive Staff, nominates topics for examination, chairs project steering committees, and directs a small professional staff and revolving group of managers/consultants.

SSA uses special, multi-disciplinary teams of individuals to conduct reengineering analyses and identify the best ways to redesign and significantly improve processes. Teams are comprised of outstanding employees, all of whom are subject matter experts in operational, programmatic, policy, systems, administrative, and other areas relevant to the business process.

Reengineering teams focus on identifying those procedural and policy changes to the process that will: make it more claimant and service oriented; greatly increase productivity and process speed; take advantage of opportunities offered by new technology; and improve the empowerment and professional enrichment of the employees who are part of the process. Although teams follow the same basic reengineering protocol, continual customization is both expected and encouraged.

## Disability Process Reengineering Project

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An Executive Steering Committee was formed to meet on a regular basis to provide advice to the Commissioner on development of the disability reengineering process change proposal, and to ensure that support occurred at the highest levels of the Agency. The

Executive Steering Committee established the following parameters and expectations for the project which are driven by targets set forth in the Agency Strategic Plan and based on percentages of service and/or productivity:

Parameters and Expectations for Reengineering the Disability Determination Process (9/15/93)

**Definition of Process**

The "process" to be reengineered is the initial and administrative appeals system for determining an individual's entitlement to Social Security and Supplemental Security Income disability payments. It includes all actions from an individual's initial contact with SSA through payment effectuation or final administrative denial. The system for determining whether an individual continues to be entitled to receive disability payments is not part of this "process."

**Rationale:** The process to be reengineered must be defined broadly to increase the opportunity for improvement. The continuing disability review system is not included because it is conceptually and practically distinct from the initial disability determination process.

**Parameters**

Every aspect of the process except the statutory definition of disability, individual benefit amounts, the use of an administrative law judge as the presiding officer for administrative hearings, and vocational rehabilitation for beneficiaries, is within the scope of this reengineering effort. However, analysis and ideas for change should proceed and be presented on two tracks: improvements achievable without changes in statute or regulations and innovations that may require such change.

**Rationale:** The timing of legislative or regulatory change is beyond SSA's control. Such change could not reasonably be expected to be implemented in less than 2 years. However, limiting the reengineering effort to aspects of the process not

requiring change in statute or regulations was rejected as limiting too greatly the possibility of major improvement/innovation in the process. The two-track approach provides for both shorter term incremental improvements and longer term, more radical change.

**Expectations**

1. Unless otherwise specified here, the recommendations for change should be consistent with the goals and objectives set forth in the Agency Strategic Plan.
2. Recommendations for change, taken as a whole, should not cause changes in benefit outlays unless as a necessary result of improvements in service, such as more timely processing and payment of claims.
3. Process changes should improve service and/or productivity, on a combined basis, by at least 25 percent by the end of FY 1997 over levels projected in the FY 1994 budget (it would require about an additional \$500 million currently to realize such improvement) and decisional accuracy should not decrease. By FY 2000 additional actions, including any necessary statutory and regulatory changes, should provide a further 25 percent improvement.

The Executive Steering Committee facilitated ongoing communications between components and the Team, and communicated the need and reason for reengineering the disability process. They were familiar with the current process problems and were kept apprised of research completed by the

Team. In February, the Executive Steering Committee was expanded to include the Presidents of the American Federation of Government Employees, the National Federation of Federal Employees, and the National Treasury Employees Union locals, councils and chapters representing SSA employees; and the Presidents of the SSA and State Disability Determination Services (DDS) professional and management associations recognized by SSA as having an interest in disability issues. A list of Executive Steering Committee members appears at the end of this appendix.

The 18 members of the Disability

Reengineering Team, all of whom are SSA or State DDS employees, have varied and extensive backgrounds in all aspects of the disability program. A list of Team members appears at the end of this chapter. Team members attended a high quality, intensive 3-day SSA reengineering methodology training session, and completed extensive reading assignments on reengineering. Some Team members visited organizations who had reengineered their business processes to learn about successes as well as opportunities for improvement. The Team used the following methods to obtain the information necessary to develop a redesigned disability process.

### Briefings

Members of the Team received extensive briefings from staff in all SSA components that work with any aspect of the disability process including experts in SSA policy, quality assurance, management information, operational, and appellate processes. Dr. Frank S. Bloch, Professor of Law and Director of the Clinical Education Center at Vanderbilt, briefed the Team on the

results of his study comparing disability programs and processes of the United States, Canada, and Western Europe. His work encompasses eligibility requirements and program goals, benefit award structure and short-term benefits, administrative organization, and procedures for claim processing and appeals.

### Scan Visits

The Team's conducted extensive fact-finding visits and interviews with members of the disability community. Team members visited 421 locations in 33 States and conducted over 3,600 interviews. Almost 2,900 of these involved front-line employees, managers and executives. The Team conducted an additional 111 interviews by telephone. The Team also interviewed over 750 parties external to SSA for their views. They also publicized surface/electronic mail addresses and fax and voice telephone numbers for those who were not contacted or had additional information to provide.

Individuals and groups both internal and external to the process were interviewed for ideas about a new process. The Team solicited a wide spectrum of opinions about problems with the current

disability process and directions for redesign. In addition to individuals in the SSA and DDS communities, the team talked to a wide variety of externals including physicians, health maintenance organizations and hospital officials, disability advocates, attorneys, professional association groups, Federal judges, other Federal agencies, and Congressional staffs.

Prior to site visits and contacts, Team members provided individuals and organizations with general information about the reengineering effort, key research areas, and some unconventional ideas about the disability process so that the interviewees would have an opportunity to think about process issues. The Team encouraged interviewees to provide open and honest opinions, suggestions, and ideas. The

interviews provided useful insights into the problems confronting the disability

program and recommendations for solving these problems.

**Focus Groups**

A series of 12 focus groups were held throughout the country to obtain input from members of our claimant population and the general public regarding their experiences with and expectations of the SSA disability process. The focus groups

provided the Team valuable information about claimants' expectations and preferences, as well as concerns about the current process. The following is a list of the focus group sites and composition.

SITE	DATE	GROUP COMPOSITION
Philadelphia, PA	11/30/93	DI Reconsideration SSI Initial Awards
Atlanta, GA	12/01/93	SSI Reconsideration DI Initial Awards
Denver, CO	12/02/93	SSI Claimants General Public
Bridgeport, CT	12/07/93	SSI Hearing DI Claimants
Chicago, IL	12/08/93	Spanish-Speaking Initial Awards General Public
San Jose, CA	12/09/93	DI Hearing Vietnamese-Speaking Applicants and Initial Awards

**Benchmarking**

"Internal benchmarking" refers to the identification and understanding of site-specific best practices that currently exist within the Agency and is focused on the improvement and standardization of internal operations. The Team completed this phase of benchmarking by reviewing lists of sites engaging in "best practices" which were submitted by various SSA components, and visiting or telephoning as many of these SSA and DDS offices as possible.

"External benchmarking" is essentially the same, except the search for best practices and proven process innovations is expanded to comparable companies and organizations outside of SSA. It is focused outside the organization and is concerned with the relative performance of one specific function or process. The table below identifies the companies/organizations the Team used as benchmarking partners.

ORGANIZATION	LOCATION
Health & Welfare Canada Income Security Programs	Ottawa, Canada
Anne Arundel Medical Center, Pathways Program	Annapolis, MD
Mayo Clinic Disability Program	Rochester, MN
Minneapolis Children's Hospital	Minneapolis, MN

ORGANIZATION	LOCATION
Blue Cross of California	Los Angeles, CA
Liberty Mutual Insurance	Boston, MA
Standard Insurance Company	Portland, OR
UNUM Corporation	Portland, ME
Department of Labor and Industries, Workers' Compensation	Olympia, WA
Immigration and Naturalization Service, Board of Immigration Appeals	Arlington, VA
Veterans Administration, Regional Office	New York City, New York
Federal Express Corporation	Columbia, MD
Southwest Airlines	Dallas, TX
Texas Instruments	Plano, TX

### Process Analysis

The Team utilized a document prepared by the SSA Office of Workforce Analysis in April 1993 which outlines the "as-is" disability claim and appeal processes of SSA. The document contains a description of claim processing tasks performed by line-employees in the seven operational components that deal

with the disability claim process. Team members also collected, reviewed, and researched an extensive amount of existing procedural guides, laws/regulations, studies conducted by internal and external components, processing time and quality management information, workflows, cost data, etc.

### Computer Modeling

Computer models are close representations of work processes that, if properly constructed, allow for better understanding, testing or forecasting, and study. Team members worked with modeling professionals in SSA to build the models used to predict the operation of a redesigned process. A model was built to represent both the current and proposed processes. The model helped

the Team assess the best features and performance of the new disability process; to better judge the magnitude of change from one process to another; and to do some "what-if-nothing-changes" analysis to get a feel for the impact of inactivity. A summary of the model assumption and results appears in Appendix II.

### Release of Initial Team Proposal

The product of the Team's effort was a redesign proposal that was presented to the Commissioner and Executive Steering Committee on March 31, 1994. The proposal provided the Team's view of the best process improvement and process innovation ideas. The proposal is a high-level concept that provides a broad understanding of how a

redesigned process would work but leaves operational, organizational, and other details for later development.

The Team distributed the proposal as widely as possible throughout SSA, the State DDSs, and to interested public and private individuals and organizations with the goal of seeking reactions, items of

concern and additional ideas for improvement. Copies of a shorter 25-page version of the Proposal were distributed to all SSA and DDS employees in early April 1994. Copies of the complete 132-page Proposal and Background Report were also distributed to each SSA DDS facility in sufficient numbers to make it easily available to staff. A 30-minute videotape containing remarks by Commissioner Chater and a presentation of the proposal by members of the Reengineering Team was distributed for use in all SSA and DDS facilities. Group feedback discussions with SSA and DDS employees were held in all ten regions and in SSA headquarters components. A survey was distributed to each SSA and DDS employee to assist employees in providing comments.

The Proposal and Background Report was published in the **Federal Register** on April 15, 1994 (59 FR 18188). A 60-day comment period was established to invite public comment on the proposal. A public hearing on the proposal was held in Washington, D.C. on May 16, 1994. Team members conducted extensive

briefings on the proposal with interested parties, including employee unions, professional association groups, disability advocates, the legal community, other Federal agencies, and Congressional staffs.

During the comment period that ended on June 14, 1994, the Team received over 6,000 written responses from all interested parties. The Team reviewed and analyzed each comment received. A summary of the comments is included in Appendix III. In response to reactions received during the comment period, the Team made changes to the original proposal and submitted a revised proposal to the Commissioner and the Executive Steering Committee on June 30, 1994.

After extensive consultation with the members of the Executive Steering Committee, SSA senior staff, representatives from employee unions and associations, disability advocates and others, the Commissioner accepted the Team's recommendations for a redesigned disability process.



## Process Reengineering Program Executive Steering Committee

Shirley Chater	Commissioner, SSA
Lawrence Thompson	Principal Deputy Commissioner, SSA
Rhoda Davis	Director, Process Reengineering Program, SSA
Dennis Brown	Moderator, Association of OHA Analysts
Bruce Bucklinger	President, OHA Managers' Association
Robert Burgess	President, National Association of Disability Examiners
Mary Chatel	President, National Council of Social Security Management Associations, Inc.
Herbert Collender	President, SSA/AFGE National Council of Payment Center Locals (Council 109)
Renato DiPentima	Deputy Commissioner for Systems, SSA
John Dyer	Deputy Commissioner for Finance, Assessment and Management, SSA
Richard Eisinger	Senior Executive Officer, SSA
George Failla	Director, Office of Information Resources Management, SSA
Gilbert Fisher	Assistant Deputy Commissioner for Programs, SSA
Howard Foard	Assistant Deputy Commissioner for Policy and External Affairs, SSA
Hilton Friend	Acting Associate Commissioner for Disability, SSA
John Gage	President, SSA/AFGE SSA Headquarters (Local 1923)
Randolph Gaines	Acting Associate General Counsel, SSA
Robert Green	SSA Regional Commissioner, Boston
Joseph Gribbin	Associate Commissioner for Program and Integrity Reviews, SSA
James Hill	President, National Treasury Employees Union (Chapter 224)
Arthur Johnson	Chief Spokesperson, SSA/AFGE General Committee
Charles Jones	Director, Michigan Disability Determination Services
David Knoll	President, SSA National Federation of Federal Employees Council of Consolidated Locals
Demos Kuchulis	President, National Association of Senior Social Security Attorneys
Antonia Lenane	Chief Policy Officer, SSA
Huldah Lieberman	Assistant Deputy Commissioner for Operations, SSA
Rose Lucas	President, SSA/AFGE National Council of Data Operations Centers (Council 221)
James Marshall	President, SSA/AFGE National Council of SSA/OHA Locals (Council 215)
Larry Massanari	SSA Regional Commissioner, Philadelphia
Francis O'Byrne	President, Association of Administrative Law Judges, Inc.
Ruth Pierce	Deputy Commissioner for Human Resources, SSA

Daniel Skoler	Associate Commissioner for Hearings and Appeals, SSA
Witold Skwierczynski	President, SSA/AFGE National Council of SSA Field Operations Locals (Council 220)
Earl Tucker	President, SSA/AFGE National Council of Social Security Regional Offices, Program Integrity Review (Council 224)
Janice Warden	Deputy Commissioner for Operations, SSA
Andrew Young	Deputy Commissioner for Programs, SSA

**Additional Support from:**

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Rosanne Hanratty	Implementation Planning Staff, Baltimore, MD
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# APPENDIX II: MODEL RESULTS

## Summary Information

The Team worked with modeling professionals in the SSA Office of Workforce Analysis (OWA) to build computer representations of both the current and the redesigned disability processes. The computer model was built using FORTRAN programming language. Data based on assumptions, task times and lapse times were input into the model. In making assumptions, the team relied on historical data to the extent that such information was available. The Team also relied on an April 1993 OWA study that outlines the current disability claim process, including all administrative appeals, and describes the tasks performed by line-employees in

the seven operational components that are involved with the disability claim process.

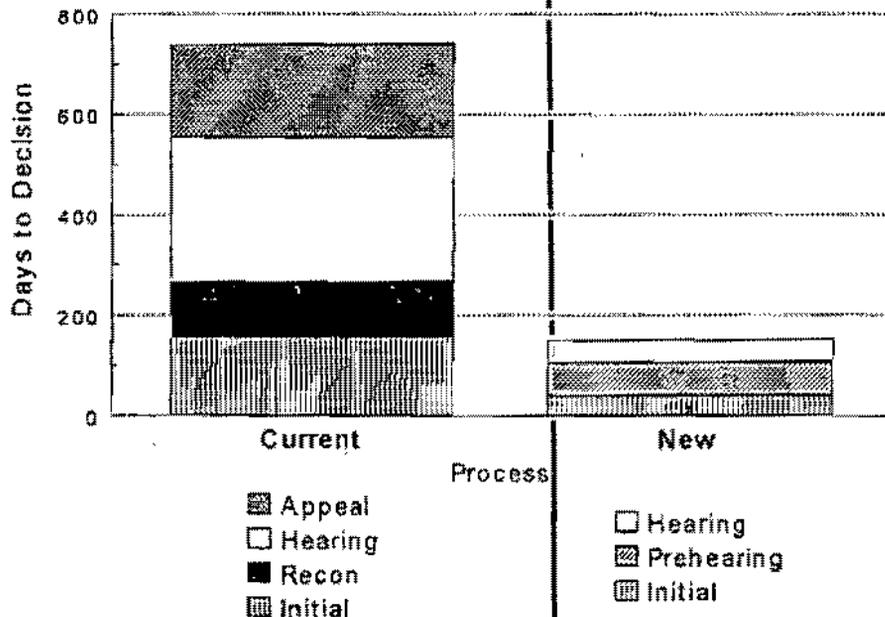
Using a computer model allowed the Team to assess the impact of changing from one process to another. Although the model did not generate an actual visual simulation of either the current or the redesigned process, the model did generate comparative data about the relative impact of specific features and expected performance. The sections that follow provide key comparative information regarding overall processing times and employee work investment based on the model results.

### Overall Processing Times

Under the redesigned process, the time from a claimant's first contact with SSA until issuance of a final initial decision will be reduced from an average of

155 days (as cited in the OWA study) to less than 40 days. Available employees will be able to process a greater number of claims and devote more time to each

Comparison of Decisional Times



claimant, thus providing more personalized service. The time from a claimant's first contact with SSA until issuance of a hearing decision will be reduced from an average of a year and a half (as cited in the OWA study) to approximately 5 months.

**Employee Work Investment**

The table below provides a comparison of the number of different employees that are likely to make some work investment in a claim at each decisional level in the current and redesigned processes: The following abbreviations were used in describing the types of employees involved at each level.

- AAJ = Administrative Appeals Judge
- AC = Appeals Council
- ALJ = Administrative Law Judge
- AO = Adjudication Officer
- CA = Claims Authorizer
- CR = Claims Representative
- DCM = Disability Claim Manager
- DDS = Disability Determination Serv.
- DE = Disability Examiner
- DW = Decision Writer
- FO = Field Office
- HAA = Hearing and Appeals Analyst
- HO = Hearing Office
- MC = Medical Consultant
- MG = Management
- OPIR = Office of Program & Integrity Reviews
- PSC = Program Service Center
- QA = Quality Analyst
- SA = Staff Attorney
- Sup = Support Staff
- TA = Technical Assistant
- TECH = FO Technician
- TSC = Teleservice Center
- TSR = TCS Representative

LEVEL	CURRENT PROCESS	REDESIGNED PROCESS
INITIAL DENIAL	16: TSR, TSC Sup, TSC TA, FO Sup, CR, FO Sup, FO MG, DDS Sup, DDS Sup, DE, DDS Sup, DDS MG, DDS Sup, DDS Sup, MC, DDS TA	7: TSR, TSC Sup, TECH, DCM, FO Sup, MC, QA
INITIAL TITLE 2 ALLOWANCE	26: Initial Denial (16) plus OPIR Sup, OPIR QA, OPIR MC, 7 PSC Sup employees	8: Initial Denial (7) plus: TECH
INITIAL TITLE 16 ALLOWANCE	19: Initial Denial (16) plus OPIR Sup, OPIR QA, OPIR MC,	8: Initial Denial (7) plus: TECH
RECONSIDERATION DENIAL	26: Initial Denial (16) plus TSR, TSC TA, FO Sup, CR, FO Sup, DDS Sup, DDS Sup, DE, MC, DDS TA	Not Applicable
RECONSIDERATION TITLE 2 ALLOWANCE	36: Recon Denial (26) plus OPIR Sup, OPIR QA, OPIR MC, 7 PSC Sup employees	Not Applicable

LEVEL	CURRENT PROCESS	REDESIGNED PROCESS
RECONSIDERATION TITLE 16 ALLOWANCE	29: Recon Denial (26) plus OPIR Sup, OPIR QA, OPIR MC	Not Applicable
PREHEARING TITLE 2 ALLOWANCE	Not Applicable	11: Initial Denial (7) plus TSR, AO, MC, TECH
PREHEARING TITLE 16 ALLOWANCE	Not Applicable	11: Initial Denial (7) plus TSR, AO, MC, TECH
HEARING DENIAL	35: Recon Denial (26) plus TSR, TSC TA, CR, HO Sup, HO Sup, HO Sup, ALJ, SA, HO Sup	15: Initial Denial (7) plus TSR, AO, MC, Hearing Sup, ALJ, DW, MC
HEARING TITLE 2 ALLOWANCE	47: Hearing Denial (35) plus 10 PSC Sup employees, CA, PSC MG	16: Hearing Denial (15) plus TECH
HEARING TITLE 16 ALLOWANCE	35: Same as Hearing Denial (35)	16: Hearing Denial (15) plus TECH
APEALS COUNCIL DENIAL	44: Hearing Denial (35) plus AC Sup, AC Sup, AC MG, HAA, AC Sup, AC TA, AC Sup, AAJ, AC Sup	18: Hearing Denial (15) plus AC Sup, HAA, AAJ 19: Hearing Allowance (16) plus AC Sup, HAA, AAJ

### Assumptions, Task Times and Lapse Times

Listed below are key assumptions, task times and lapse times that the Team used to model the redesigned process. The task times are shown in minutes and represent the estimated time it will take an employee to complete the described task. For each task time entry, three task time numbers are shown. The middle

number represents the most common task time, while the first and last number represent the low and high extremes for that task. The lapse times are shown in work days, rather than calendar days, and represent the number of days between actions or tasks.

#### INITIAL LEVEL

- Electronic files will be used in the process redesign.
- Electronic files will eliminate mail time and allow simultaneous reviews of claim files.
- Disability information packets will be widely available. The goal is to target the information to likely applicants and ensure they have a better understanding of the program(s), the requirements and the decisionmaking methodology when they enter the process. Increased public information will

enhance claimant involvement in the process and ultimately decrease processing times.

- 50% of all disability interviews will be by appointment. Of these, 75% will be by telephone and 25% will be face-to-face interviews.
- 50% of all appointments will be scheduled via the 1-800 number and the remaining 50% by field components.
- 35% of all disability interviews will be unscheduled walk-ins.
- 10% of all disability applications will be submitted by third parties.
- 5% of all disability applications will be submitted electronically.
- When filed, a hearing appeals request must be made within 60 calendar days of the issuance of the initial denial notice.
- Preliminary initial inquiry interview time: 14-23-35 minutes
- Lapse time between preliminary initial inquiry interview and scheduled appointment: 3-4-5 days
- Initial application interview time: 30-45-75 minutes
- Impairment specific questions will assist in obtaining information that is necessary and relevant to the decision and personalize and streamline the interviewing process.
- 3% of telephone interviews will result in abandoned claims.
- Receipt of application/evidence time: 5-10-15 minutes
- Preliminary nonmedical development and review time: 20-40-60 minutes
- 8.5% of all claims will be technically denied.
- 4.5% of all Title 16 claims adopt Title 2 decisions.
- SSA will encourage claimants, who are able to do so, to have the basic forms in the disability information packet completed prior to filing.
- 20% of all claimants will submit sufficient evidence to make a decision at the time of the interview or receipt of the application.
- 80% of all claimants will not submit evidence sufficient to make a decision at the time of the interview or receipt of the application.
- Medical evidence of record (MER) will be requested in 75% of all claims requiring evidence. Assuming that MER will generally include complete functional assessment (FA) information, in 25% of these claims, a separate FA will be needed.

- Consultative examinations (CEs) will be requested in 25% of all claims requiring evidence. CEs will contain FA information.
- CEs will generally be requested for claimants that have no treating source, or their treating source is unable or unwilling to provide the necessary evidence, or there is a conflict in the evidence that can not be resolved through treating source evidence.
- Medical evidence request time:
 

MER:	10-15-20 minutes
CEs:	10-15-20 minutes
FAs:	10-15-20 minutes
- Lapse time between request and receipt of medical evidence:
 

MER:	4-10-20 days
CEs:	6-10-14 days
FAs:	6-10-14 days
- The use of standardized forms to request medical evidence will streamline the collection of necessary evidence.
- A national fee reimbursement schedule will utilize a sliding mechanism to reward early submission of medical evidence, as well as, the quality of evidence received.
- The process of requesting medical evidence will be fully automated. Follow up letters for medical evidence will also be automatically generated by the claim processing system.
- The procurement and payment process for medical evidence will be fully automated.
- On average, number of pieces of MER requested or submitted: 1-2-3 pieces
- Evidence receipt, case association, record update time: 3-7-15 minutes
- Medical evidence review and analysis time:
 

MER:	10-15-20 minutes
CEs:	10-15-20 minutes
FAs:	20-25-30 minutes
- Field components will have established local contracts with area hospitals/medical centers/etc. to provide CEs and FAs within specified timeframes.
- Automation will, where possible, allow direct contact between the field component and the CE and/or FA source for scheduling purposes.
- 40% of all cases will require medical consultation.
- Medical consultation time: 25-30-45 minutes
- Initial level medical adjudication time: 10-15-30 minutes

- Approximate percent of cases allowed at the initial level prior to issuance of predecision notice: 45%
- Approximate percent of cases allowed at the initial level after issuance of the predecision notice and additional review: 4%
- Predecision notice preparation time: 5-10-20 minutes
- Lapse time to submit evidence or request personal interview after issuance of predecision notice: 10 days
- 50% of the cases receiving predecision notices will request personal interviews.
- 50% of the cases not requesting a personal interview will submit (or require) additional evidence.
- 50% of the cases requesting a personal conference will also submit (or require) additional evidence.
- On average, the number of new pieces of evidence requested or submitted: 2 pieces
- Personal interviews will be conducted in person, by videoconference, by telephone, or by whatever means the field component determines is appropriate under the circumstances.
- Personal interview time: 30-45-60 minutes
- Evidence receipt, case association, record update time: 3-7-15 minutes
- Predecision analysis and review time: 10-30-45 minutes
- 40% of all predecision notice cases will require medical consultation.
- Medical consultation time: 25-30-45 minutes
- 73% of allowances are Title 16 or concurrent claims. 47% are Title 2 or concurrent claims.
- Lapse time between claimant contact and effectuation interview: 3-4-5 days
- 75% of effectuation interviews are face-to-face and 25% are completed by telephone.
- 90% of effectuation interviews will require that additional evidence be submitted after the interview.
- Lapse time between effectuation interview and submission of evidence: 2-10-18 days
- Receipt of effectuation application/evidence time: 5-10-15 minutes

- Title 16 effectuation interview and review and analysis of evidence time: 50-100-145 minutes
- Average technical effectuation assistance time: 10-20-35 minutes
- Preparation of "statement of claim" time: 20-30-40 minutes
- Notices at both levels of the process will be prepared using the automated claim processing and the decision support system.

## HEARING LEVEL

- Percentage of initial denials filing a hearing request (H/R): 45%
- Representation level at the hearing stage will drop to 50%.
- 50% of all appeal interviews will be by appointment. Of these, 75% will be by telephone and 25% will be face-to-face interviews.
- 50% of all appeal appointments will be scheduled via the 1-800 number and the remaining 50% by field components.
- Preliminary appeal interview time: 14-23-35 minutes
- H/R interview time: 20-25-30 minutes

## ADJUDICATION OFFICER

- Initial review of H/R and file time: 10-15-30 minutes
- Preliminary telephone/letter contact with claimant and/or representative time: 20-30-45 minutes
- A hearing will be scheduled using the automated claim processing system approximately 45 days after the R/H has been filed. Numerous factors (i.e., leave, training, etc.) will be considered when creating the hearing dockets.
- 50% of the R/Hs will request a personal conference.
- Lapse time between preliminary contact and personal conference: 5-10-15 days
- Percentage of cases requiring time for submission of additional evidence after personal conference: 30%
- On average, number of pieces of evidence requested or submitted: 2 pieces
- Lapse time between personal conference and receipt of evidence: 10-20-30 days
- Evidence receipt, case association, record update time: 3-7-15 minutes
- Analysis and review of evidence time: 10-20-30 minutes

- 25% of all personal conference cases will require medical consultation.
- Medical consultation time: 25-30-45 minutes
- Allowance decision preparation time: 30-45-60 minutes
- Stipulation preparation time: 45-60-75 minutes
- Approximate percent of R/H cases allowed prior to ALJ hearing: 25%
- Approximate percent of R/H cases referred to an ALJ for hearing: 75%

**ADMINISTRATIVE LAW JUDGE**

- ALJ prehearing review and analysis time: 20-40-60 minutes
- Length of hearing time: 20-40-60 minutes
- 25% of all hearing cases will require medical consultation.
- Medical consultation time: 25-30-45 minutes
- 10% of all hearing cases will submit (or require) additional evidence after the hearing.
- Lapse time between hearing and receipt of evidence: 10-20-30 days
- Request and evidence receipt time: 10-15-30 minutes
- Analysis and instruction preparation time: 10-15-20 minutes
- Preparation of allowance decision time: 30-45-60 minutes
- Preparation of denial decision time: 60-90-120 minutes
- Final editing and preparation of decision time: 5-10-15 minutes
- Final review and sign off time: 10-15-20 minutes
- Approximate percent of cases allowed at ALJ level: 20%
- Approximate percent of cases denied at ALJ level: 80%

**APPEALS COUNCIL OWN-MOTION PREEFFECTUATION REVIEW**

- Minimum percent of ALJ cases selected for own motion preeffectuation review: 5%
- Lapse time for own motion preeffectuation review: 8-12-20 days
- Routing and case control function time: 13-15-17 minutes
- Analysis and recommendation time: 105-150-180 minutes

New Disability Claim Process

- Final review and approval time: 15-30-60 minutes
- Results of preeffactuation own motion review:
  - Affirmed: 90%
  - Reversed: 2%
  - Remanded: 8%

**MISCELLANEOUS**

- Minimum percent of cases filing civil actions: 5%
- Percent of cases filing a civil action will decrease as overall claimant satisfaction increases and overall processing times decrease.
- The court affirmation rate will rise and the remand rate will decrease as the quality of SSA decisions is enhanced as the Agency implements the various component pieces of the process redesign. This result will also affect (decrease) the percent of cases filing a civil action.

## APPENDIX III: SUMMARY OF COMMENTS ON REENGINEERING PROPOSAL

### Overview

During the comment period that began on April 1, 1994 and ended on June 14, 1994, the Team received over 6,000 written responses from SSA and DDS employees, employee unions, professional associations, members of the public, claimant representatives, physicians, State governors, claimant advocate groups, Federal components, and other interested parties. Fifty-three percent of the written responses came from SSA employees, 21% came from DDS employees, and 26% came from individuals and organizations external to the SSA/DDS community. Members of the Team read, analyzed, and collated every one of those 6,210 comments so that no idea, reaction, or nuance would be overlooked.

For the commenters who presented written reactions to the overall proposal, 52% were favorable to the overall concept, 39% were unfavorable, and 9% were neutral. Approximately 10% of these commenters believed no reengineering was needed.

Beyond the request for written comments, additional means of gauging reaction to the proposal were also employed: group employee feedback discussions were held in over 80 sites across the country with almost 2,000 SSA and DDS employees participating; a public meeting was held in Washington, D.C.; and Team members conducted briefings and spoke with more than 3,000 individuals and organizations about the proposal during the comment period.

There was a very mixed reaction to the proposal. Very few verbal or written responses were totally favorable or unfavorable toward the proposal--those liking it had concerns about some elements while those generally disliking it found portions which they believed would be improvements over the current process. Many commenters, regardless of expressing praise or concern, addressed very limited aspects of the proposal without providing a reaction to the overall proposal.

### Profile

The comments expressed can be categorized as follows:

- SSA received widespread praise for taking on the task of redesigning the disability claim process. The prevalent belief was that dramatic improvements are needed to provide better service and handle workloads more effectively. Whether fully supporting the proposal or not, most commenters expressed concern that the system is broken and that only

radical redesign will solve the problems that currently exist.

- The most popular concepts were (*listed from most to least frequently mentioned*):

- elimination of the reconsideration step;
- the disability claim manager as single Agency point of contact in the initial claim;

- a single presentation of substantive policies for all decision makers;
  - encouragement of the claimant to be a partner in the development of the claim;
  - elimination of the mandatory Appeals Council review step;
  - increased reliance on the use of information technology;
  - increased public awareness and education about program requirements;
  - evidence development tailored to claimant circumstances;
  - disability claim managers empowered with full decisionmaking authority; and
  - the general aspects of the proposed disability methodology.
- The greatest concerns centered around (*listed from most to least frequently mentioned*):
- personal safety of disability claim managers;
  - ability of one person to fulfill the disability claim manager role;
  - pre-denial personal interview with disability claim manager;
  - the general aspects of the proposed disability methodology;
  - encouragement of the claimant to be a partner in the development of the claim;
  - the disability claim manager as single Agency point of contact in the initial claim;
- development and use of an Index of Disabling Impairments;
    - use of standardized forms to request evidence from treating sources;
    - reliance on treating source certification of existing evidence; and
    - potential bias of disability claim managers.
- Many of the responses centered around how the proposal would be implemented and what organizational changes would be needed to make the new process work.
- There were concerns about whether the proposal would meet the objective of not increasing or decreasing program costs with fairly divided opinions about whether the new disability methodology would allow or deny more claims than the current methodology. Reliance on treating sources as preferred sources of medical evidence and personal bias resulting from disability claim manager face-to-face meetings with claimants were often cited as the reason for the belief that there will be an overall increase in allowed claims. The new four-step evaluation process was cited as the most common reason for the belief that there will be an overall increase in denied claims.