Disability Process Redesign: The Proposal from the SSA Disability Process Reengineering Team

About a year ago, the Social Security Administration (SSA) began the Disability Process Reengineering Program. This agency-wide project is one way SSA is seeking to improve its overall service to its customers while enriching and improving the worklives of its employees.

The Disability Process Reengineering Team's objective is to fundamentally rethink and redesign SSA's disability programs under OASDI and SSI to achieve dramatic improvements in critical measures of performance. The Team asked, "If SSA had the opportunity today to design the processes, what would they look like?"

The Disability Reengineering Team's proposal to SSA for reengineering the disability process was announced in the *Federal Register* (April 15, 1994, pp. 18188–18264). This is not the final proposal; comments from the public were solicited in the announcement. This note gives a brief description of the new process proposed by the Team as well as a summary of the current process.

Introduction

A claimant for disability benefits from the Social Security Administration faces a lengthy, bewildering process. An initial decision from SSA will likely take more than three months. Anywhere from 16 to 26 employees will handle the claim before the initial decision is reached. If that decision is a denial, and the request for reconsideration is also denied, chances are the claimant will hire an attorney. It will likely be an additional 8 months or more before a response on the hearing is received, and even longer before a check is issued or eligible dependents' benefits are paid. As many as 45 employees could handle the claim.

If the claim for benefits is approved after a hearing, the claimant will view the SSA disability application process as one which requires jumping through lengthy bureaucratic hoops. Dealing in person or on the telephone with SSA field office staff and, possibly, the State disability determination service (DDS) staff at the initial and reconsideration levels, the claimant must appear at a hearing to finally talk to a person in a position to make a decision on the claim. The claimant will rate SSA employees as courteous and knowledgeable, but the disability determination process as bureaucratic and unresponsive.

SSA employees reiterate this belief, as illustrated in the following statement by a claims representative, "I wish we could stop shuffling all this stuff back and forth. I don't really know what the DDS is looking for, so I try to do the best generic job I can on these forms."

SSA has reached a critical juncture; disability claims receipts at the initial claims and appeals levels have reached all time highs—fiscal year (FY) 1995 claims requiring a disability determination will increase 69 percent over FY 1990 levels; appeals workloads will increase 75 percent over FY 1990 receipt levels; employees in field offices, DDSs and hearing offices are overburdened despite recent significant increases in productivity. As an agency, SSA must vie for scarce administrative resources in an era of spending limitations and competing social spending priorities. The ability of SSA to cope with further workload increases is questionable; it is clear that only radical change can address the disability service delivery problems facing the Agency today.

SSA is meeting this challenge with an unprecedented effort to reengineer the entire disability process—from the point a potential claimant first contacts the Agency to file for disability benefits, through the disability allowance or final administrative appeal. Reengineering the disability process involves asking the question,"Given what we know about technology and resources available to us today, how can we best design a disability process for the 1990's and beyond?" This report will answer that question by proposing a radical redesign of disability program policies and procedures, to ensure dramatic improvements in the way the entire process works and is managed to serve the American public.

The report represents the collective efforts and recommendations of the 18-member Disability Reengineering Team, composed of Federal and State employees, operating under the auspices of the Director of the SSA Process Reengineering Program, and the SSA Executive Steering Committee formed to provide advice to the Commissioner on the disability reengineering process change proposal development.

The Executive Steering Committee provided the following parameters for the disability reengineering proposal: "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."

Current Process

The current disability process served SSA and the public well for a number of years. However, over the last several years, as workloads have increased dramatically, the current process has been placed under increasing stress.

The procedures in the current process have not changed in any significant way since the Social Security Disability Insurance (DI) program began in the 1950's, a time when caseloads, demographic characteristics of claimants, types of disabilities, and available technology were radically different. In the 1970's, Congress federalized State programs of cash assistance to the aged, blind and disabled into the Supplemental Security Income (SSI) program and added this to the responsibilities of SSA. SSA then adopted the DI disability determination procedures for SSI blind and disabled claims.

The upward trend in the number of claims for benefits SSA has received is reflected in the increases in disability initial claims and appeals workload receipts over the last several years. These increases have occurred concurrently with significant downsizing activity in SSA and staffing fluctuations in the State DDSs. Even so, the total costs for processing initial disability and appeals determinations remain enormous—more than half of SSA's total $4.9 billion administrative costs in FY 1993 were devoted to these tasks.

Despite these funds, and despite directing a larger percentage of SSA's 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. Initial claims processing time is up from about 80 days in FY 1988 to approximately 100 days today. The average time to process a hearing has grown from about 212 days in FY 1988 to about 265 days today.

A claim must now pass through from 1 to 4 decisional paths within SSA to receive a favorable disability decision. The initial claim, reconsideration, administrative law judge (ALJ) hearing and Appeals Council review levels all involve multi-step uniform procedures for evidence collection, review, and decisionmaking.

An initial claim currently takes an average of 100 days to process from the time it is filed until a final decision is made according to SSA's computer-based processing time measurements. However, a better understanding of how long the process takes from the claimant's perspective 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*. Sixteen to 26 employees handle the claim during this period.

An average reconsideration itself takes about 50 days according to SSA's computer-based processing time reports—however, according to the Office of Workforce Analysis study, a claimant is involved with the SSA process for roughly 8 months from the point of initially contacting the Agency, and up to 36 different employees could handle the claim.

The hearing process itself takes about 265 days and Appeals Council reviews about 100 days according to computer-based reports. However, according to the Office of Workforce Analysis study, a claimant has been dealing with SSA for over a year and a half at the time a hearing decision is issued, and about two years by the time the Appeals Council decision is issued.

At least part of the recent increases in processing time result from the time added as the claim moves from one employee or facility to another (hand-offs), 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 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.

The Team's research methodology called for extensive site visits and interviews with members of the disability community. Team members visited 421 locations in 33 States and conducted over 3,600 interviews with SSA front-line employees, managers and executives, and with members of the medical, legal, advocate and interest group community—in order to obtain their views. Additionally, the Team analyzed the results of focus groups involving disability claimants and the general public in order to determine what SSA customers experience and expect from the disability process.

New Process

Overview

A claimant for disability benefits under the proposed process will be provided a full explanation of SSA's programs and processes at the initial contact with SSA. The claimant and third parties will be able to assist in the development of the claim, deal with a single contact point in the Agency, and request a personal interview with the decision maker at each level of the process. If the claimant requests a hearing, the issues and evidence to be addressed at the hearing will be focused, the responsibilities of representatives clarified and, if the claim is approved, the effectuation of payment to the claimant, eligible dependents and the representative streamlined.

The new process will result in a correct decision at the initial level by simplifying the decision methodology, providing consistent direction and training to all decision makers, enhancing the collection and development of medical evidence, and employing a single quality review process across all levels.

A single claim manager will handle most aspects of the initial level claim, thus eliminating many steps caused by numerous employees handling discrete parts of the claim (hand-offs) 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 medical 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 proposed process will enable the current work force to handle an increased number of claims, freeing the most highly skilled 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 proposed process will facilitate employees' ability to do the total job by providing technology and the support to use that technology.

The New Process —A Brief Description

Under the proposed process, the number of appeal steps will be reduced and opportunities for personal interaction with decision makers will be increased. At the initial claim level, the claimant will be offered a range of options for filing a claim, pursuing evidence collection, and conferring with a decisionmaker, using various modes of technology to interact with SSA. At the hearing level, the claimant will have an additional opportunity to participate in a personal conference and meet with a decisionmaker.

Claimants initially will deal almost exclusively with a disability claim manager—a front-line employee knowledgeable about the medical and nonmedical factors of entitlement—responsible for making the initial determination, with technical support if necessary, to allow or deny the claim.

The disability claim manager will determine the level of development needed to make a disability decision using a simplified determination methodology; relying on evidence submitted through the efforts of the claimant (whenever the claimant is able to do this); requesting medical evidence or a functional assessment; or referring complex medical questions to a medical consultant for expert advice and opinion, if necessary. The disability claim manager will contact the claimant if the decision on a claim appears to be a denial. The claim manager will explain the situation including the evidence that was considered, and offer the claimant an opportunity to submit additional information as well as an option for an interview in-person or via telephone, before the claim is formally denied.

All initial claims will be subject to a randomly selected postadjudicative national sample review designed to determine whether disability policies are being properly applied. Extensive ongoing training will enable adjudicators to consistently issue correct decisions. By the time the initial decision is issued, the claim will have been handled by seven or eight employees.

A claimant wishing to appeal an unfavorable initial decision to an ALJ will continue to have 60 days to file a request for a hearing. The disability claim manager will assist the claimant with the request, and forward the claim to an adjudication officer. The adjudication officer will be responsible for explaining the hearing process to the claimant, as well as conducting personal conferences, preparing claims, and scheduling hearings. The adjudication officer will have the authority to allow the claim at any point prior to the hearing that sufficient evidence becomes available to support a favorable decision.

The ALJ will conduct the hearing and issue the decision. At any point in the process where the claim is approved, it will be returned to the claim manager for payment effectuation, whether the claim is DI, concurrent, or SSI. Denied claims will be forwarded to the Appeals Council, for retention in the event of civil action. At this point, an average claimant will have been dealing with SSA for approximately five months from the first contact with the Agency. A total of up to 14 employees will have been involved with the process during this entire period.

An ALJ decision will be the final decision of the Secretary, subject to judicial review, unless the Appeals Council reviews the ALJ decision on its own motion. The Appeals Council will conduct reviews of ALJ allowances and denials prior to effectuation, at its discretion, and on its own motion. The Appeals Council will also review all claims in which a civil action has been filed, and decide whether the ALJ decision should be defended as the final decision of the Secretary. If a claim is selected for own motion review, a total of 17 employees will have been involved in the process from first claimant contact with SSA through Appeals Council review.

The time from a claimant's first contact with SSA until issuance of a final decision will be reduced from an average of 155 days (as cited in SSA's Office of Workforce Analysis study) to less than 40 days, enhancing SSA's capacity to provide world-class service. Available employees will be able to process a greater number of claims, and devote more time to each claimant, 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 SSA's Office of Workforce Analysis study) to approximately 5 months.

Summary of Differences

New Process	Current Process
Process Entry	
Claimant has program information, starter application and means to gather evidence before entry	Claimant has limited or no program information available prior to entry
Claimant files by mail, electronically, telephone or in person	Claimant files by mail, telephone, or in person
Claims Intake	
Interview with claims manager trained in disability and nondisability aspects of program	Interview with claims representative trained only in nondisability aspects of program
Single point of contact for all claims processing	Multiple contacts with different claims specialists
Disability Decision Methodology (Adult)	
4-step approach:	**5-step sequential evaluation:**
Engaging in substantial gainful activity	Engaging in substantial gainful activity
Medically determinable impairment	Severe impairment
Impairment is in Index of Disabling Impairments (no medical equivalence or assessing function)	Meets or equals Listings of Impairments
	Able to do past relevant work
Able to perform substantial gainful activity ("Grid" eliminated)	Able to do other work (using the "Grid")
Disability Decision Methodology (Child)	
4-step approach:	4-step sequential approach:
Engaging in substantial gainful activity	Engaging in substantial gainful activity
Medically determinable impairment	Severe impairment
Impairment is in Index of Disabling Impairments (no medical equivalence or assessing function)	Meets or equals Listings of Impairments
Comparable severity	Comparable severity
Evidentiary Development	
Claimant is a partner in obtaining medical evidence	SSA takes responsibility for obtaining medical evidence
SSA obtains evidence necessary to decide issues in the claim	SSA obtains detailed clinical and laboratory findings in all claims
SSA, working with medical experts, develops standarized instruments and criteria for measuring a claimant's functional ability	SSA uses objective findings, medical opinion, and other evidence to assess a claimant's residual functional capacity

Summary of Differences—Continued

Initial Disability Determination	
Claims manager decides claim after appropriate consultation with physician	Disability specialist and physician team decide claim based on paper review
Reconsideration	
Reconsideration eliminated	Paper review by different disability specialist physician team
Administrative Law Judge Hearing	
Hearing request must be filed within 60 days of initial determination	Hearing request must be filed within 60 days of reconsideration
Adjudication officer oversees prehearing development	ALJ is responsible for overseeing all prehearing development
Personal conference is mandatory if claimant is represented	Prehearing conference is held in limited circumstances
Appeals Council Review	
Appeals Council reviews claim only on its own motion; review is limited to the record before the ALJ	Claimant requests Appeals Council review and the Appeals Council may consider new evidence
Appeals Council action is not a prerequisite for judicial review	Appeals Council action is a prerequisite for judicial review
Quality Assurance	
Quality assurance will address customer satisfaction, employee education/performance, and error prevention; end-of-line reviews will measure quality of the entire adjudicative process	Quality measurements focus primarily on end-of-line disability decision accuracy; quality is not consistently measured at all levels of administrative review
Process Integrity	
A single policy book will be used by all adjudicators at all levels of administrative review	Adjudicative standards and policies are available through a variety of instructional vehicles
Ongoing training will be provided to all disability decisionmakers and support personnel	Consistent training is not provided to disability decisionmakers