



**CONSORTIUM FOR CITIZENS  
WITH DISABILITIES**

June 13, 2014

The Honorable James Lankford  
Chair  
Subcommittee on Energy Policy, Health Care and Entitlements  
Committee on Oversight and Government Reform  
U.S. House of Representatives  
2157 Rayburn House Office Building  
Washington, DC 20515

The Honorable Jackie Speier  
Ranking Member  
Subcommittee on Energy Policy, Health Care and Entitlements  
Committee on Oversight and Government Reform  
U.S. House of Representatives  
211 Cannon House Office Building  
Washington, DC 20515

**RE: April 8, 2014 Letter to Acting Commissioner of Social Security Carolyn Colvin**

Dear Chairman Lankford and Ranking Member Speier,

We are writing this letter on behalf of the undersigned members of the Consortium for Citizens with Disabilities (CCD) Social Security Task Force to provide feedback on your April 8, 2014 letter to the Acting Commissioner of Social Security, Carolyn W. Colvin.

CCD is a working coalition of national consumer, advocacy, provider, and professional organizations working together with and on behalf of the 57 million children and adults with disabilities and their families living in the United States. CCD's Social Security Task Force focuses on disability policy issues in the Title II disability programs and the Title XVI Supplemental Security Income (SSI) program.

Social Security's disability programs are a core component of our nation's Social Security system, which keeps millions of hardworking Americans and their families out of poverty. Along with related benefits under Medicare and Medicaid, SSI and Social Security Disability Insurance (SSDI) provide vital and much-needed economic security and access to health care for individuals whose impairments are so severe that they preclude substantial work. Extremely strict eligibility requirements mean that fewer than four in ten applicants are approved for disability benefits, even after all stages of appeal. Demonstrating eligibility requires extensive medical evidence, and many individuals are denied benefits despite significant disabilities and chronic illnesses.

Benefits are modest but vital – averaging just over \$500 per month for SSI and just over \$1,100 per month for SSDI. For many, disability benefits make it possible to secure stable housing and purchase food, life-sustaining medications, and other basic necessities. Disability benefits can be the difference between life and death for many Americans.

## **I. Recommendations for Strengthening SSA’s Program Integrity Work**

The CCD Social Security Task Force shares your belief in the importance of ensuring that Social Security disability payments are only made to people who are entitled to receive them and that the amount of the payments are accurate. Although the Social Security Administration (SSA) does a good job of ensuring that payments are accurate, we believe that more could be done to prevent overpayments and underpayments. It is important to note that, in and of themselves, **overpayments do not indicate fraud or abuse as beneficiaries are encouraged to work if they are able.**

Over the years, the CCD Social Security Task Force has developed many recommendations for strengthening SSA’s program integrity work. A detailed description of our recommendations is available at:

[http://www.c-c-d.org/fichiers/CCD\\_Program\\_Integrity-Recommendations06-09-14.pdf](http://www.c-c-d.org/fichiers/CCD_Program_Integrity-Recommendations06-09-14.pdf).

As highlighted in our recommendations, the CCD Social Security Task Force shares your support for SSA’s ability to conduct Continuing Disability Reviews (CDRs) in a timely manner and for efforts by the Office of Disability Adjudication and Review to enhance decisional quality. We appreciate your work to emphasize the importance of program integrity initiatives.

## **II. SSA Requires Adequate Resources for Program Integrity**

Unfortunately, we are deeply concerned that without adequate resources, SSA will continue to struggle to meet the service needs of the public and ensure program integrity. We thank Ranking Member Speier for highlighting this concern in her opening statement at the Subcommittee’s April 9, 2014 hearing. We concur that SSA must have sufficient resources to carry out program integrity activities, as well as customer service functions.

SSA’s administrative budget is only about 1.4 percent of benefits paid out each year. With the baby boomers entering retirement and their disability prone years, SSA is experiencing dramatic workload increases at a time of diminished funding and staff. For the two years prior to fiscal year (FY) 2014, Congress appropriated \$421 million less for SSA’s program integrity efforts (such as medical and work continuing disability reviews and Title XVI redeterminations) than the Budget Control Act of 2011 (BCA) authorized. Over the three years prior to FY 2014, SSA received nearly \$1 billion less for its Limitation on Administrative Expenses (LAE) than the President’s request, and lost over 11,000 employees since FY 2011. We are encouraged that the appropriation for FY 2014 includes full funding of the FY 2014 BCA level for SSA’s program integrity reviews. This will allow SSA to significantly increase CDRs.

Adequate LAE is essential to preventing service degradation and ensuring that SSA can provide timely and accurate payments and perform necessary program integrity work, including:

• **Disability claims processing.** Adequate resources support claims processing and disability determinations at the initial levels so that the correct decision can be made at the earliest point possible and unnecessary appeals can be avoided. Inadequate staffing at field offices and state Disability Determination Services (DDS) leads to increased workload at the hearing level. Disability claims may be less thoroughly developed, leading to incorrect denials of benefits and more appeals. Additionally, the significant progress made in recent years at the hearing level in reducing average wait times until hearings and shrinking the disability claims backlog has eroded due to the lack of needed resources.

• **Pre-effectuation and continuance reviews<sup>1</sup> of DDS determinations.** As required by the Social Security Act, SSA conducts pre-effectuation reviews of at least half of all DDS initial and reconsideration allowances for Title II (Social Security) and Title XVI (Supplemental Security Income) adult disability benefits. SSA also reviews a number of DDS Title II CDR determinations, which result in continuation of benefits. For every dollar spent in FY 2011 on these reviews SSA estimates a lifetime savings of about \$11 in Title II and Title XVI benefits.<sup>2</sup>

• **Disability Determination Services quality review.** SSA has implemented multiple levels of quality review at the DDS level. For example, SSA requires all DDSs to have an internal quality assurance function, and also operates an Office of Quality Performance (OQP) which conducts quality assurance reviews of samples of initial and reconsideration determinations of the DDSs.

• **Review of Administrative Law Judge (ALJ) decisions in a manner consistent with law.** While ALJs have qualified decisional independence, they are required to follow SSA laws, regulations and policies. SSA has implemented a quality review process for ALJ decisions. In FY 2011, the SSA Office of Disability Adjudication and Review (ODAR) established a new Quality Review (QR) initiative and opened four new Branches in the Office of Appellate Operations. The QR Branches review a computer-generated sample of unappealed favorable ALJ decisions (over 6,100 in FY 2013), pre-effectuation, and then refer the selected cases to the Appeals Council for possible “own motion” review. If the Appeals Council accepts review, it can remand or issue “corrective” decisions, which may involve changing the favorable ALJ decision to a “partially” favorable decision or to an unfavorable decision. In addition, there is post-effectuation review of ALJ decisions, i.e., review after the decisions are effectuated and beneficiaries are in pay status. While these ALJ decisions cannot be changed, post-effectuation review enables targeted examination of compliance with agency policies and policy guidance and additional training as needed to ensure high quality decision-making.

• **CDRs and redeterminations.** SSA is required by law to conduct CDRs in all cases where the beneficiary’s condition is expected to improve, or where improvement is considered possible, to ensure that benefits are paid only as long as the individual remains eligible. SSA estimates that every \$1 spent on medical CDRs saves the federal government \$9, but reports a current backlog of 1.3 million CDRs. We are hopeful that the additional resources in the FY 2014 budget will allow SSA to significantly increase the number of medical and work CDRs and SSI redeterminations it is able to conduct.

• **Cooperative Disability Investigations (CDI).** SSA and the Office of the Inspector General (OIG) jointly established the CDI Program in 1998. Twenty-five CDI units across the U.S. investigate

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<sup>1</sup> “Pre-effectuation” refers to reviews conducted before benefits are authorized to be paid. Accordingly, “continuance reviews” and “post-effectuation reviews” are conducted after benefit authorization.

<sup>2</sup> Social Security Administration, June 27, 2013, Annual Report on Social Security Pre-Effectuation Reviews of Favorable State Disability Determinations, Fiscal Year 2011.

individual disability applicants and beneficiaries, as well as potential third parties who facilitate disability fraud. SSA or DDS personnel make referrals to a CDI unit for investigation, and CDI units also accept reports from the public via a toll-free telephone hotline and an online web form. Investigations uncovering fraud or attempted fraud can result in a denial, suspension, or termination of benefits, civil or criminal prosecution, and/or imposition of civil monetary penalties, and/or sanctions on claimant representatives for violation of SSA's ethical standards. Since the program's inception in FY 1998, CDI efforts have resulted in \$2.2 billion in projected savings to SSA's disability programs, with more than \$860 million just over the last three years, as Acting Commissioner Colvin noted in her testimony for a recent hearing before the House Ways and Means Social Security Subcommittee.<sup>3</sup>

### **III. SSA Should Retain the Medical Improvement Review Standard**

Your letter recommends that SSA revise the Medical Improvement Review Standard (MIRS), which requires that SSA show medical improvement before benefits can be terminated. The CCD Social Security Task Force has long taken the position that SSA should retain the MIRS as it currently exists in the Social Security Act and the regulations.

As discussed below, the circumstances under which beneficiaries' benefits were improperly terminated in the early 1980s using the initial disability standard and without the need for SSA to show any change in the beneficiary's condition from the prior determination led Congress to consider and ultimately pass, after lengthy deliberation, legislation establishing the MIRS.

Congress passed the standard as part of the Social Security Disability Benefits Reform Act of 1984 ("DBRA 1984"; Pub. L. No. 98-460) – legislation passed by a unanimous, bipartisan vote in both the House of Representatives (402-0) and the Senate (99-0) in September 1984, and was enacted when signed by President Reagan on October 9, 1984. A number of exceptions to application of the MIRS were provided in the legislation, including cases where the prior decision was "in error." If fraud was involved, benefits can be terminated retroactively and the individual may be referred for further sanctions.

#### **DBRA 1984: History and Rationale**

The years leading up to DBRA 1984 highlight the need for and the importance of the medical improvement standard.

In 1980, legislation created a requirement that SSA conduct CDRs every three years for beneficiaries whose impairment(s) were not considered permanent. The then-new Reagan Administration implemented a policy in early 1981 of aggressively conducting CDRs and terminating the benefits of those who did not meet its strict interpretation of the Social Security initial disability standard. This included elimination of any requirement to show medical improvement as well as a *de novo* review of CDR cases under the new, stricter policy.<sup>4</sup>

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<sup>3</sup> Hearing on Fighting Social Security Disability Fraud, Subcommittee on Social Security, House Committee on Ways and Means, Feb. 26, 2014; testimony available at [http://waysandmeans.house.gov/uploadedfiles/2\\_26\\_14\\_ss\\_testimony\\_carolyn\\_colvin.pdf](http://waysandmeans.house.gov/uploadedfiles/2_26_14_ss_testimony_carolyn_colvin.pdf).

<sup>4</sup> Evidence of the shift in interpretation of the 1980 legislation is shown in the estimated savings for conducting CDRs. The 1980 conference report estimated savings from 1982 to 1985 of \$218 million, with a net loss at the

Chaos and significant harm to beneficiaries ensued. About 1 million beneficiaries were subject to the three-year CDR review, and between March 1981 and early 1984, federal-funded state Disability Determination Services agencies terminated the benefits of almost 500,000 disabled Americans, including tens of thousands of beneficiaries with severe mental impairments. Chaos resulted. Twenty-nine states refused to follow SSA's instructions for termination of benefits; federal courts were clogged with appeals; 200 federal courts across the country threatened the government with contempt of court citations for refusing to pay benefits when ordered.

Litigation challenging the Administration's policy was instituted across the country, including more than 12,000 individual appeals of terminations and 40 class actions. Many courts ordered SSA to apply a "medical improvement" standard before terminating disability benefits and one-half of the States refused to follow SSA's new procedures and criteria. By April 1984, the Administration finally announced a nationwide moratorium on CDRs.

Beginning in 1982, Congress began to consider legislation that, among other provisions, required SSA to apply a "medical improvement" standard before terminating benefits. **The intent of the standard was that benefits should be continued if the individual's condition remains the same as or is worse than it was when benefits were first granted.**

The final bill leading to enactment of DBRA 1984 was described by Members of Congress from both parties as a necessity to end the chaos. On the day the bill was passed, then Rep. J. J. Pickle (D-TX), a previous Chairman of the House Ways and Means Social Security Subcommittee, stated on the floor of the House:

... [T]oday the program is in a state of chaos and if we do not act immediately to restore order, it will utterly collapse. Perhaps my cry of alarm sounds exaggerated. It is not.

### **The Medical Improvement Review Standard**

Section 2(a) of DBRA 1984 sets forth the medical improvement review standard (MIRS): SSA shall terminate disability benefits "only if such finding is supported by —

- (1) substantial evidence which demonstrates that—
  - (A) there has been any medical improvement in the individual's impairment or combination of impairments (other than medical improvement which is not related to the individual's ability to work), and
  - (B) the individual is now able to engage in substantial gainful activity."<sup>5</sup>

"Medical improvement" is defined as: "[A]ny decrease in the medical severity of your impairment(s) which was present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled."<sup>6</sup>

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beginning due to increased administrative resources. On the other hand, the Reagan Administration submitted information to Congress estimating savings of \$2.4 billion from 1981 to 1985, with no additional resources.

<sup>5</sup> 42 U.S.C. §§ 423(f)(1) and 1382c(a)(4)(A).

<sup>6</sup> 20 C.F.R. §§ 404.1594(b)(1) and 416.994 (b)(1)(i).

SSA will only consider the impairments that the individual had at the time of the last disability decision, and not those which have developed since that time. However, SSA will consider any new impairments when it assesses whether the person is now able to engage in substantial gainful activity (assuming medical improvement of prior impairment(s) is found) under the second prong of the statutory standard.

SSA will find that there has been medical improvement if only one impairment has improved, even if another impairment(s) present at the time of the most recent favorable decision has worsened.

### **Exceptions to application of the Medical Improvement Review Standard**

When Congress approved the medical improvement standard in DBRA 1984, the extensive deliberations, lasting more than two years, also resulted in a number of exceptions to application of the MIRS. These exceptions are divided into two groups.

**First group of exceptions to application of the MIRS.** In the first group of exceptions, the individual has not improved medically. Under the sequence of review,<sup>7</sup> the consideration of the case will proceed to determine whether the individual is currently able to engage in SGA. Exceptions in this first group include: (1) Advances in medical or vocational therapy or technology; (2) The beneficiary has undergone vocational therapy; (3) New or improved diagnostic techniques or evaluations have become generally available; and (4) Any prior disability decision was “in error.”

The exception to application of the MIRS when there is substantial evidence which demonstrates that any prior disability determination was “in error” is very specific.<sup>8</sup> It will apply “only if” one of the following three circumstances exists:

- 1. Substantial evidence shows “on its face” that the decision in question should not have been made.** This covers errors such as misreading test results or the misapplication of a listed impairment in the Listings of Impairments or one of the Medical-Vocational Guideline rules. Examples are provided in the regulation. If this error applies, SSA will still determine current eligibility for benefits.
- 2. At the time of the last review, required and material evidence of the severity of the impairment(s) “was missing.”** This exception may apply when evidence becomes available on the review and substantial evidence demonstrates that had such evidence been present at the time of the prior determination, disability would not have been found. “Missing” evidence refers to material evidence that was not obtained but was required for documentation, such as the Listing of Impairments.<sup>9</sup>
- 3. New evidence which relates to the prior determination and refutes the prior conclusions.** This exception applies only if: “New evidence” which relates to the prior determination ... “refutes the conclusions that were based upon the prior evidence” *and* there is substantial evidence that “had the new evidence ... been considered at the time of the prior decision, ... the claim would not have been allowed or continued.”<sup>10</sup> The type of error contemplated,

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<sup>7</sup> 20 C.F.R. §§ 404.1594(f) and 416.994(b)(5).

<sup>8</sup> 20 C.F.R. §§ 404.1594(d)(4) and 416.994(b)(3)(iv).

<sup>9</sup> POMS DI 28020.360.

<sup>10</sup> 20 C.F.R. §§ 404.1594(d)(4)(iii) and 416.994(b)(3)(iv)(C).

which is an example in the regulation, is “a tumor thought to be malignant was later shown to have actually been benign.”

The regulation clearly prohibits “substitution of judgment” for applying the “in error” exception:

A substitution of current judgment for that used in the prior favorable decision will not be the basis for applying the exception.<sup>11</sup>

The regulation provides an example where substitution of judgment is *not* proper. The example discusses a previous adjudicator who found that the individual’s diabetes met the level of severity in the Listing of Impairments. On the review, symptoms, signs, and laboratory findings are unchanged. However, the current adjudicator feels the impairment does not meet a Listing. “Error *cannot* be found because it would represent a substitution of current judgment for that of the prior adjudicator that your impairment equaled a listing.” (emphasis in original).

If error is found, SSA will consider whether it is appropriate to reopen the prior decision. This will occur only if the regulatory conditions for reopening a prior decision are met.<sup>12</sup> If reopening does not apply, SSA will not make a finding that disability ended in the past. Instead, it will make a determination as to whether the individual is currently able to engage in SGA.

**Second group of exceptions to application of the MIRS.** If one of the exceptions in the second group applies, a finding of “no disability” will result and benefits terminated, even if there has been no medical improvement and the individual cannot currently engage in substantial gainful activity (SGA). The second group of exceptions includes: (1) The prior decision was fraudulently obtained; (2) The individual does not cooperate with SSA and there is no “good cause” for the failure; (3) SSA cannot locate the individual; and (4) The individual fails to follow prescribed treatment which would be expected to restore the ability to engage in SGA and there is no “good cause” for the failure.

If one of the exceptions in the second group applies, the statute<sup>13</sup> permits SSA to discontinue benefits, regardless of whether there is medical improvement.<sup>14</sup> If the prior decision was obtained by fraud, SSA can reopen the claim at any time<sup>15</sup> and retroactively terminate benefits. SSA can also determine whether further sanctions are appropriate.

#### **IV. Proposal to Submit “All Evidence” Could Create Significant Barriers to Eligibility for Individuals with Qualifying Disabilities**

Your letter recommends that SSA “should require claimants and their representatives to submit all evidence.”

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<sup>11</sup> *Id.*

<sup>12</sup> See 20 C.F.R. §§ 404.988-404.989 and 416.1488-416.1489. A disability decision may be reopened “for any reason” within 12 months of the initial determination finding the individual disabled; for “good cause” (e.g., “new and material evidence is furnished”) within 2 years (SSI) or 4 years (Title II) of the initial determination finding the individual disabled; or “[a]t any time” if fraud was involved in obtaining the initial determination.

<sup>13</sup> 42 U.S.C. § 423(f).

<sup>14</sup> 20 C.F.R. §§ 404.1594(e)(1) and 416.994(b)(4)(i).

<sup>15</sup> 20 C.F.R. §§ 404.988(c) and 416.1488(c).

SSA recently issued a Notice of Proposed Rulemaking (NPRM) to do this. “Submission of Evidence in Disability Claims.” 79 Fed. Reg. 9663 (Feb. 20, 2014). The NPRM proposed requiring that a claimant “must inform us [SSA] about or submit all evidence known to you that relates to whether or not you are blind or disabled.” Additionally, the NPRM would require the claimant to submit evidence “in its entirety.” The NPRM preface explains: “For example, if you obtain your patient file from one of your medical sources, we would require you to submit *all* of the medical records in that file.” 79 Fed. Reg. 9666 (emphasis in original).

In comments submitted on April 21, 2014, CCD members express grave concern about the impact of the proposed rule on people with disabilities, noting that any changes to the process must be measured against the extent to which the changes ensure fairness and protect the rights of people with disabilities. As stated in the CCD comments:

Rather than removing “subjectivity,” the NPRM instead provides no limit in the scope or relevance of evidence that must be submitted. It will allow unlimited discretion in adjudicators, for example inappropriately prying into claimants’ private lives, and will undoubtedly be subject to disparate application. And the lack of specific guidance will lead to confusion and potential “traps” for claimants and their representatives, inefficiencies for all parties, and significant workload increases for SSA staff.

The CCD comments go on to explain:

We support the concept that records should not be “redacted,” as required by the current § 404.1512(c). However, the proposed requirement to submit evidence “in its entirety” must be considered in the context of the complete proposed regulations. As discussed above, the proposed regulations provide no specificity or guidance and require, with a seemingly unlimited scope, the claimant to submit hundreds and perhaps thousands of pages of records. For example, a single hospitalization may easily consist of 1000 or more pages. Is the agency, especially at the hearing level, prepared to review of hundreds if not thousands of pages of medical records, when perhaps only 20 pages may be relevant?

Given that the NPRM would require records to be submitted in their “entirety,” it is likely that thousands of pages of medical records would need to be obtained and submitted. While the NPRM infers that it would be sufficient to “inform” SSA about the evidence, the reality of who will obtain and pay for the evidence is not so clear, as claimants and their representatives are generally required, at least at the hearing level, to obtain and pay for the evidence.

The full CCD comments are available at:

[http://www.c-c-d.org/fichiers/CCD\\_Comments\\_evidence\\_NPRM4-21-2014FINAL.pdf](http://www.c-c-d.org/fichiers/CCD_Comments_evidence_NPRM4-21-2014FINAL.pdf).

## **V. Treating Physician Rule and Acceptable Medical Sources**

Your letter recommends that SSA “revise the ‘treating source’ rule to allow ALJs to consider all relevant medical conditions.” As described below, the CCD Social Security Task Force believes that SSA’s current regulations and policies for weighing medical evidence in disability claims provide detailed guidance for adjudicators and the public, and we support their appropriate application.

We agree with the Administrative Conference of the United States (ACUS) recommendation cited in your letter that SSA should revise its rules so that “other medical professionals such as nurse practitioners, physician assistants, and licensed clinical social workers can be considered acceptable medical sources.”

### *Treating Physician Rule*

Prior to 1991, SSA had failed to promulgate comprehensive rules for weighing medical evidence in disability claims. As a result, the courts stepped in to fill the void and established an extensive collection of precedent in this area. The “treating physician rule” existed in every circuit and provided fairly similar guidance. Generally, the opinion of a treating physician was to be given more weight than that of a consulting or nonexamining physician. Finally, in 1991, SSA moved to address this problem when it published final rules describing the weight to be given all medical evidence, including reports from treating physicians and consultative examinations.<sup>16</sup> The extensive case law played an important role in development of the regulations. Even SSA stated that it had “been guided” by basic principles upon which the majority of circuit courts generally agreed:

1. “[T]reating source evidence tends to have a special intrinsic value by virtue of the treating source’s relationship with the claimant.”
2. “[I]f the Secretary [now Commissioner] decides to reject such an opinion, he should provide the claimant with good reasons for doing so.”<sup>17</sup>

The current regulations require adjudicators to “evaluate every medical opinion we [i. e., SSA] receive” when determining the weight to give these opinions, including those from treating sources.<sup>18</sup> The regulations also require adjudicators to “consider all of the ... factors [in the regulations] in deciding the weight we give to any medical opinion”<sup>19</sup> and to “make findings about what the evidence shows.”<sup>20</sup> Consistent with the second guiding principle for the regulations, the courts have required adjudicators to provide a rationale, explaining how the factors were applied to determine the weight given to medical opinions and to provide valid reasons for discounting or rejecting the opinions of treating sources.

Unless a treating source opinion is entitled to controlling weight, SSA’s regulations already provide that all medical opinions are evaluated under the same factors.<sup>21</sup> These factors are: (1) treatment relationship, including length of relationship, frequency of examination, and nature and extent of treatment relationship; (2) supportability; (3) consistency; and (4) specialization.<sup>22</sup>

It should be noted that evidence from a treating source is not automatically accorded “controlling weight.” Under the regulations, a treating source’s opinion is given controlling weight *only if*: (1) it is “well-supported by medically acceptable clinical and laboratory diagnostic techniques”; and (2) it

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<sup>16</sup> 56 Fed. Reg. 36932 (Aug. 1, 1991).

<sup>17</sup> *Id.* at 36934.

<sup>18</sup> 20 C.F.R. §§ 404.1527(d) and 416.927(d).

<sup>19</sup> *Id.*

<sup>20</sup> 20 C.F.R. §§ 404.1527(c) and 416.927(c).

<sup>21</sup> 20 C.F.R. §§ 404.1527(d) and 416.927(d).

<sup>22</sup> 20 C.F.R. §§ 404.1527(d)(2)–(d)(6) and 416.927(d)(2)–(d)(6).

is “not inconsistent with the other substantial evidence in your case record.”<sup>23</sup> If a treating source opinion is not given controlling weight, SSA will apply the other factors listed above.<sup>24</sup>

### **Acceptable Medical Sources**

SSA should expand the list of “acceptable medical sources” to include nurse practitioners, physician assistants, and licensed clinical social workers. Delays in the disability claims process often arise when SSA requires a consultative examination to confirm the diagnosis made by a nurse practitioner, physician assistant, or licensed clinical social worker. Millions of Americans rely on these licensed practitioners as their primary providers of physical and mental health care. Based on current trends, these health professionals will become an increasing part of the nation’s healthcare workforce – a role that the federal government is committed to promoting. Because these professionals are licensed by states, expanding the list of acceptable medical sources to include them protects the integrity of the disability programs. Most importantly, it will streamline the process, ensuring that eligible individuals access benefits in a timely manner.

## **VI. Hearing Notice and Closing the Evidentiary Record**

The CCD Social Security Task Force has long recommended that SSA increase the time for providing advance notice of the hearing date from the current 20 days to 75 days. We thank you for highlighting this option in your letter. An increase to 75 days would allow more time to obtain medical evidence before the hearing and make it far more likely that the record will be complete when the ALJ reviews the file before the hearing. The 75-day time period has been in effect in SSA’s Region I states since August 2006 and, based on reports from representatives, has worked well.

We strongly support the submission of evidence as early as possible, since it means that a correct decision can be made at the earliest point possible. However, there are many legitimate reasons why evidence is not submitted earlier and thus why closing the record is not beneficial to claimants, including: (1) worsening of the medical condition which forms the basis of the claim; (2) factors outside the claimant’s control, such as medical provider delay in sending evidence; and (3) the need to keep the process informal and focused on determining whether the individual is eligible for disability benefits to which he or she is statutorily entitled.

The CCD Social Security Task Force opposes proposals to limit the ability to submit evidence within a set number of days before the hearing and/or to close the record entirely after the ALJ hearing is held. There have been a number of such proposals offered over the years. We believe that these proposals are neither beneficial to claimants nor administratively efficient for the agency.

Under current law, new evidence can be submitted to an ALJ and it must be considered in reaching a decision.<sup>25</sup> Contrary to assertions by some that there is an unlimited ability to submit new evidence after the ALJ hearing, the current regulations and statute are very specific in limiting that ability at later levels of appeal. At the Appeals Council level, new evidence will be considered, but only if the Appeals Council determines it relates to the period before the ALJ decision and is “new and

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<sup>23</sup> 20 C.F.R. §§ 404.1527(d)(2) and 416.927(d)(2).

<sup>24</sup> *Id.*

<sup>25</sup> 42 U.S.C. § 405(b)(1). Current regulations comply with the statute by providing that the claimant may submit new evidence at the hearing. 20 C.F.R. §§ 404.929 and 416.1429.

material.”<sup>26</sup> While the Appeals Council remands less than one-in-five appeals filed by claimants, the reason for most remands is not the submission of new evidence, but rather legal errors committed by the ALJ, including the failure to consider existing evidence according to SSA regulations and policy, the failure to apply the correct legal standards, and the failure to articulate the rationale for discounting evidence and/or testimony.

At the federal court level, the record is closed and the court will not consider new evidence in its decision-making process. However, the court does have the authority to remand the case for SSA to consider the additional evidence, but only if the new evidence is (1) “new” and (2) “material” and (3) there is “good cause” for the failure to submit it in the prior administrative proceedings.<sup>27</sup> Because courts hold claimants to the stringent standard in the Act, remands occur very infrequently under this part of the statute. The vast majority of court remands are not based on new evidence, but are ordered under the statute due to legal errors committed by the ALJ.

## **VII. Review of Applicants’ Social Media Accounts**

Your letter recommends that SSA personnel should be allowed to review each applicant’s social media accounts prior to the decision to award benefits, and that SSA should require that all CDRs incorporate a review of such accounts. We have grave concerns about this approach and its potential impact on claimants, decisional quality, and workload, as well as the security of SSA’s data systems. We agree with SSA’s policy to allow consideration of social media accounts but only after referral to personnel who are trained to investigate allegations of fraud or similar fault, primarily in a measured approach by the SSA Office of Inspector General.

The reliability of social media is often low and difficult to ascertain. For example, it may be difficult to tell whether a photograph was taken before or after the onset of a disability, whether a social media post was intended seriously or in jest, or whether a series of social media posts reflects a person putting on their best face for friends and family as opposed to the reality of their day to day life. It can also be difficult to identify whether an account was actually established by a claimant or beneficiary. Even former Commissioner Michael Astrue stated during a May 17, 2012 Senate Finance Committee hearing<sup>28</sup> that he had not created a Facebook page but had been signed up by others. Computer technology makes it very easy for a malicious person to create a social media account under someone else’s name, or to create pictures or videos that depict a person falsely, for example, by pasting a person’s face onto a picture of someone else or inserting false information.

For these reasons, any information reviewed on social media must be carefully evaluated and corroborated by specially trained investigative personnel. Indeed, as described by SSA, its Cooperative Disability Investigative Units (CDIUs) do precisely that: “CDIUs often use Internet or social networking sites as a starting point for their investigations. However, they corroborate this information and do not base their findings on uncorroborated information.”<sup>29</sup>

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<sup>26</sup> 20 C.F.R. §§ 404.970(b) and 416.1470(b).

<sup>27</sup> 42 U.S.C. § 405(g).

<sup>28</sup> The Social Security Administration: Is It Meeting its Responsibilities to Save Taxpayer Dollars and Serve the Public?, Senate Finance Committee, May 17, 2012, available at <http://www.finance.senate.gov/hearings/hearing/?id=35b30665-5056-a032-52b7-89db5b56d235>.

<sup>29</sup> SSA Administrative Message AM-12053, Effective Date: 04/16/2012, “Credibility Assessment, Personally Identifiable Information, Internet and Social Media Network Sites, and Suspected Fraud.”

Because social media can generate a large volume of information, the corroboration process may be very time-consuming and require specialized knowledge. SSA adjudicators, including DDS disability examiners and ALJs, lack the time, resources, and expertise to investigate potentially criminal and or fraudulent activities.

We believe that the current process, under which SSA personnel who become aware of potential fraud are instructed to report the suspected fraud to staffs who specialize in investigating and corroborating potential fraud, is appropriate. This approach was supported by the SSA Inspector General in his response to questioning at your Subcommittee's April 9, 2014 hearing. He stated that he had concerns about allowing access to social media by all SSA personnel, noting that social media should be viewed in context as a "tool" or a "clue."

Additionally, it is vital that SSA maintain the integrity of its data systems to protect the confidential information of the American people. Any risk of a data breach at SSA is unacceptable. In testimony before the Senate Finance Committee on May 17, 2012,<sup>30</sup> former Commissioner Astrue described SSA's computer firewall as "the toughest" to break through. Former Commissioner Astrue stated that to ensure security, no SSA employee can access Facebook from his or her work computer, and that the agency's policy on access to social media protects privacy and prevents malware from entering the SSA computer system. As noted by the agency:

Adjudicators and reviewers must not use Internet sites and social media networks to obtain information about claimants to adjudicate cases, except as outlined below in cases involving suspected fraud. Entering PII [personally identifiable information] in an Internet search engine or social media network may compromise the confidentiality of PII. The responsibility to protect PII within an employee's control applies at all times, regardless of whether the employee is at an official duty station, another official work location, an alternate duty station, or off duty. This policy applies whether the individual is using a computer or personal device (for example, Blackberry or Smartphone).<sup>31</sup>

### **VIII. Modernization of the Medical-Vocational Guidelines**

The Medical-Vocational Guidelines,<sup>32</sup> when issued in 1980, were supported by the Dictionary of Occupational Titles (DOT). The DOT is used by the state Disability Determination Services and Administrative Law Judges to identify jobs that claimants might be able to perform in light of their functional limitations and vocational characteristics.

We agree that the DOT needs to be updated. SSA has signed an interagency agreement with the U.S. Department of Labor's Bureau of Labor Statistics (BLS). More detailed information about the agreement is available at [http://www.ssa.gov/disabilityresearch/occupational\\_info\\_systems.html](http://www.ssa.gov/disabilityresearch/occupational_info_systems.html). We support SSA's efforts to develop a new Occupational Information System (OIS) to update and/or replace the DOT by working in conjunction the BLS.

Initially, SSA worked on creating a new OIS on its own. However, for some years, we believed that SSA should collaborate with other agencies that have established expertise and we support the

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<sup>30</sup> See note 29.

<sup>31</sup> *Id.*

<sup>32</sup> 20 C.F.R., Pt. 404, Subpt. P, App. 2 (2012).

Agency's current plan to work with the Department of Labor in the interest of efficient use of government resources. The SSA-BLS partnership has been successful to date and we believe that it will result in a more up-to-date and well-supported occupational information system for SSA.

We understand that SSA, through its Disability Research Consortium, is conducting a review of recent literature, reports, studies, and other materials that could impact the factors used in the Medical-Vocational Guidelines. SSA will then be able to use this information to decide whether changes are needed to the Guidelines. We support this evidence-based approach.

We do not support an increase in the age categories. Critics of the current age categories<sup>33</sup> argue that since there is evidence that the average health of older workers has improved and many older persons are working, the age categories in the Medical-Vocational Guidelines should be adjusted upward. However, these trends have little to do with the work capacity of persons with severe health problems or disabilities who are not working and have applied for disability benefits. That is, the average health of a population reveals little about the individuals who apply for disability benefits, who by definition are not enjoying the average health of the population at large.

Not all segments of the population have benefited from improvements in health and working conditions. In particular, individuals with lower incomes and less education might be especially disadvantaged by changes to the Guidelines, since these groups have benefited the least from overall improvements in the health of the general population.<sup>34</sup> These persons who are found disabled under the Guidelines have the most adverse vocational characteristics – low education, lack of work skills, and limited residual functional capacity. When these factors are combined, the Guidelines recognize that the occupational opportunities are so restricted that a finding of “disabled” is warranted. These are the very individuals who would be harmed by increasing the age categories of the Medical-Vocational Guidelines.

We support SSA's approach to thoroughly research and assess how age, education, and work experience impact the ability to work in current jobs that exist in significant numbers in our economy.

## **IX. Use of Video Hearings**

We support the use of video hearings so long as the right to a full and fair hearing is adequately protected; the quality of video hearings is assured; and the claimant retains the absolute right to have an in-person hearing as provided under current regulations<sup>35</sup> and SSA policy.

Video hearings allow ALJs to conduct hearings without being at the same geographical site as the claimant and representative and have the potential to reduce processing times and increase productivity. The claimant makes the ultimate decision whether to accept the video hearing.

In general, representatives report that video hearings are usually accepted, primarily because they lead to faster adjudication. However, there are a number of reasons why a claimant may decline and choose to exercise the right to an in-person hearing, e.g., the claimant's demeanor is critical (e.g.,

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<sup>33</sup> 20 C.F.R. §§ 404.1563 and 416.963 (2012).

<sup>34</sup> See, for example, <http://www.nih.gov/news/pr/aug2006/nia-16.htm>.

<sup>35</sup> 20 C.F.R. §§ 404.936 and 416.1436.

respiratory impairments, fatigue caused by impairment); the claimant has a mental impairment with symptoms of paranoia; the claimant has a hearing impairment.

### **Conclusion**

Thank you for consideration of our concerns and comments. For further information, please contact CCD Social Security Task Force Co-Chair TJ Sutcliffe, The Arc of the United States, [sutcliffe@thearc.org](mailto:sutcliffe@thearc.org), or Task Force member Lisa D. Ekman, Health and Disability Advocates, [lekman@hdadvocates.org](mailto:lekman@hdadvocates.org).

### **On behalf of:**

Association of University Centers on Disabilities  
Health and Disability Advocates  
Lutheran Services in America Disability Network  
National Alliance on Mental Illness  
National Association of Disability Representatives  
National Committee to Preserve Social Security and Medicare  
National Organization of Social Security Claimants' Representatives  
National Senior Citizens Law Center  
Paralyzed Veterans of America  
The Arc of the United States  
The Special Needs Alliance  
United Spinal Association

CC: Members, U.S. House of Representatives Committee on Oversight and Government Reform  
The Honorable Sam Johnson, Chair, U.S. House of Representatives, Committee on Ways and Means, Subcommittee on Social Security  
The Honorable Xavier Beccera, Ranking Member, U.S. House of Representatives, Committee on Ways and Means, Subcommittee on Social Security  
The Honorable Carolyn W. Colvin, Acting Commissioner, Social Security Administration