

**Social Security Advisory Board
NYC Trip Summary
March 23-24, 2015**

Meeting with Regional Executives

Budget and staffing. Executives stated that after two good budgets, the offices have been able to hire new employees and extend service hours. However, they now have many trainees that will take a while to learn their jobs.

Technology. New technology is changing communication with the public. This change is greater in educated suburban areas than in disability-prone poor areas with greater language diversity. Technology has helped offset the loss of employees, but not completely because Disability and SSI require the most manpower.

Service. Unions claim that the public receives better service in person, but the agency disagrees. Due to social conventions, the public will ask more questions in person and interviews take longer. The agency believes online interaction will get better over time with review and advances in technology.

Claimant representatives. Executives have had difficulty with claimant representatives committing fraud in their region and delaying claims on purpose. They wanted to have better tools for acting against bad actors.

Meeting with Regional Management

Space Allocation. SSA has frozen space allocation to reduce the agency's footprint. This has led to staff reduction in certain offices and reduced service area since renovated offices often have fewer interviewing windows. The agency and union have fought over office layout, workspace station, and ergonomic furniture. The unions would prefer to have more work stations in the back office for processing paperwork and to reduce isolation from coworkers. The agency states that this hurts service to the public by reducing windows and increasing crowds in the waiting room.

Outdated computers. Due to budget shortfalls and rigid spending rules, some PC's have not been replaced and are out of warranty. The agency is transitioning to laptops, but worries that there could be computer shortages during the two-year transition.

Staffing. Retirements and attrition have caused unbalanced staffing. Imbalances create longer wait times. Transferring workload can even things out across offices, but wait times are still long overall.

Staffing flexibility. The offices reevaluate service delivery frequently and move staff as needed. This is done when consolidating offices as well. Staff can be moved temporarily or are asked to volunteer to shift offices. The agency rarely forces employees to switch offices.

Workload Support Units (WSU). The agency has developed a pilot of WSUs to process disability claims. The agency says it is too soon to judge the effectiveness. Managers worried the WSUs would take the easier cases and not reduce workload much at local offices.

Federal control of DDSs. Management stated they would like to see federal control of DDSs since SSA funds their operations. They felt this would give SSA more control over workloads across the state and reduce the impact of state politics in DDS locations.

Meeting with Regional Non-management Staff

Loss of Institutional Knowledge. Due to attrition and a gap in hiring, there has been a lack of mentoring available to bring newer employees to the knowledge level of seasoned employees.

Challenging Workloads. Field office workloads have become more challenging as easier tasks are now being handled through internet filing or WSU processing. Difficult cases take longer and contribute to longer waiting times in offices. There are many manual processes that have no systems support such as SSI couple cases, attorney fee issues, and SSI Trusts.

SSI Trusts. SSI trusts, while rare, are workload intensive because of complicated rules. Each case takes 7-8 hours to review. Claims representatives are expected to understand and implement state laws in accordance with Social Security regulations but are lacking the needed training. The problem with SSI Trusts has been exacerbated in New York with the retirement of the regional expert in this field.

Overpayments. Overpayment issues are difficult due to the different systems available to calculate them. The Title 16 (SSI) system is easier to deal with, because if the amounts of wages, other income and living arrangements are correctly entered into the system, the overpayment is correctly calculated. There are still some problems with SSI couples' cases, and certain manual computations where overpayments must be carried over to subsequent records. Title 2 records are not as clear, and different employees have different access to the system to determine overpayments. This often results in conflicting amounts for overpayments, making it difficult to collect improper payments. It embarrasses SSA components (OGC) when attempting to explain overpayments to the ALJ or in court. If amounts in file conflict with each other, the ALJ often waives the overpayment, even if it is legitimate.

Training. SSA trains employees initially, but follow-up training on specific difficult issues is inconsistent. Employees would like more training with 'policy' staff to ensure consistent policy application. It used to take a newly-hired employee about one year to be fully knowledgeable and comfortable in the position. That process is almost double now. Lack of sufficient field office staff generally means that the new employee does not have a mentor to assist in reviewing cases. Supervisors are often tasked to do this, but they have many competing duties.

Customer service vs. workload. The agency is highly focused on numbers and this can conflict with public service. Employees feel they must rush to complete tasks with the public. The goals and expectations of the agency and the public do not coincide. Many field offices are unable to process the number of calls they receive. Employees felt workload could be more evenly distributed throughout the fiscal year if the budget was more predictable. Workloads that are compressed to certain quarters of the fiscal year due to politics reduce employee morale.

Systems. SSA is still using many outdated systems programs, and has not migrated to an internet-based platform for processing. This means that the systems do not interact with each other, and easily leads to mistakes in processing, which is detrimental to customer service. There are many duplicative inputs due the lack of systems integration. An overhaul of the system to create one integrated system would be very costly.

Specialized staffing. Most field office employees favor returning to the concept of specialists – either Title 2 Claims or SSI Claims specialists. They feel that expertise would be increased and that there would be fewer errors. However, some employees felt customer service was enhanced by service from claims representatives who were knowledgeable about both programs.

Meeting with DDS Managers

State control of DDSs. Managers would prefer that DDSs be federalized. Currently, state employees leave to work in the federal DDSs to make more money. Managers feel constricted by state hiring rules that prevent some states from being able to hire experienced examiners from another state at a level appropriate to their prior experience.

Disability Case Processing System (DCPS). Managers are looking forward to DCPS being rolled out since it will reduce costs spent on the state systems maintenance and upgrades. They believe it will assist with moving work around between offices.

Prototype v. reconsideration. Managers from prototype and non-prototype states agreed that it would be better for public service to reinstitute the reconsideration step even though it would create work for the DDS in prototype states. The states would need some money to hire staff for the reconsiderations, but this would reduce the work at ODAR. Managers agreed the process should be unified across the country. In an ideal world, the prototype might have worked, but ODAR cannot presently handle the additional cases. Reconsiderations are good at weeding out cases prior to ODAR and correctly allowing some cases earlier.

Single-decision maker (SDM). Managers unanimously agreed that SSA should expand the SDM pilot nationwide. The SDM avoids the bottleneck waiting for medical consultants. Medical consultants who work for DDSs can be slow because they work part-time and usually for a lower salary than doctors in private practice. They can also be difficult to work with because of the legal vs. medical terms being applied in the disability assessment. They sometimes have trouble taking direction from “lay” staff.

Claimant representatives. Claimant representatives are not very helpful until the hearing level when the incentive for fees becomes much higher. This partially explains the high allowance

rates at the hearing level. It also makes the DDSs look bad because cases get reversed that were properly denied based on lack of evidence. Managers hope the duty of candor regulation will help.

Meeting with ODAR Judges

Administrative law judge (ALJ) shortage. ODAR stated that they need more ALJs to keep up with the high number of hearings and backlog. When a large number of judges were hired in 2008, the pending time of hearings went down. The problem of not enough judges is rising again as judges are retiring and the major hiring has stopped, while the number of hearing receipts is increasing. The hiring that was done this year was helped by an early budget, because the selection process is better when not rushed. Retirements are occurring at a high rate and 250 new hires would allow retiree backfill and some planned growth. It takes a couple of years for the full impact of new hires to be felt as the hires learn the job. Puerto Rico is most impacted by not enough ALJs – issues include the bilingual requirement, high number of transfer requests, cost of living, and quality of life perception.

Problems with OPM. OPM screens and interviews candidates before they get to SSA. Despite OPM having pre-screened candidates, the percentage of quality candidates is frustratingly low. Many candidates show lack of judgment in their interview responses, do not have enough experience, or lack the necessary interpersonal skills.

Decision writing. There is debate about centralized decision writing versus having a writer assigned to a judge and case from the beginning. As long as communication is open, centralized decision writing can work. ALJs need to contact writers with instructions and writers need to go back to the judge if clarification is needed. Teleworking is occurring already, so there should be little difference between working with a decision writer across town or across the country.

Performance goals. SSA is still looking to ALJs to clear 500-700 cases per year. SSA is looking at the writers' numbers and revising the Decision Writers Statistical Index, a performance measurement.

Congressional visits. The largest constituent complaint from Congressional staffers involves the hearing process. ODAR used to be able to take staffers on a tour of a hearing office, which was helpful to them, but now ODAR must go through public affairs. There are still discussions between staffers and ODAR at least once a week.

Policy compliance. The paramount requirement for ALJs is to produce a policy-compliant decision. There is no pressure to rule one way or another; the decision remains with the judge. However, decisions must be legally sufficient. To monitor this, ODAR conducts random in-line quality reviews. Although judges may differ on a decision or the interpretation of laws, how an

ALJ comes to a decision must be policy compliant. Approval percentages at either end of the range, such as 90% to 10%, are most likely indicative of policy non-compliance. There is no set amount of time a judge should spend on a case, but they need to use time efficiently and develop the skill of knowing where one's time is best spent.

Meeting with OGC

Potential challenges to policy. The economy and technology has changed, resulting in less blue-collar type work. The grids and occupational titles going back to the 1970s have not reflected this shift. This results in challenges in analyzing a case and obtaining vocational experts. A person's functional limitations and what he/she can still do in the job market is an important question in analyzing a disability claim. Resolving this issue should be a priority, but it is beyond the scope of OGC.

Caseload. About 18,000 benefit litigation cases per year go to federal court. Many federal court cases involve mental impairments, or a combination of physical and mental impairments, and are not clear-cut. There is an increased caseload due to the recession. The cases that get to the litigation stage are usually about 2 ½ years subsequent to the date of the initial decision.

Federal court outcomes. Assuming there are quality decisions at lower levels, the case goes forward because the claimant still feels that he is disabled even after the Appeals Council denies review of the case. About 40% of the cases prevail in federal court. Few of this 40% are approved at the federal court level. Most cases are remanded back to the administrative level for further development. The court reviews the record – the administrative record, transcript, medical evidence, oral hearing transcription, and hearing decision. The court ensures that there is substantial evidence, which is a standard below preponderance of the evidence. The judge is deciding if the decision is legally sufficient or if there is legal error.

Costs. About 75% of OGC's 700 employees' time is spent on benefit litigation. The cost comes out of the SSA budget. For the plaintiffs' attorneys, more is involved than just attorneys' fees coming out of the claimant's benefit award. There are Equal Access to Justice fees, capped hourly, which come out of the Treasury. Reasonable fees are determined by the judge.

Remanded cases. Remanded cases return to the original ALJ who decided the claim. ALJs sometimes wonder why OGC did not defend the agency more vigorously or why the federal court sent it back. DOJ, the litigator for the federal government, is not going to defend vigorously if there is no widespread impact. The federal court makes sure claimants get the benefit of the doubt.

SAUSA program. SSA has gotten more authority and credibility in court under the Special Assistant to the US Attorney (SAUSA) program. OGC acts as special assistant to DOJ, allowing better litigation in court as SSA attorneys are experts on SSA policy and DOJ attorneys are not.

Restitution. For fraud cases, there are mechanisms for collecting money even if someone is not receiving benefits, such as tax refund offset, wage garnishment, civil monetary penalties, and criminal restitution. These are not solely under OGC's control.

Standardizing court rules. Having standard rules nationally for presentation of cases would be helpful. States and magistrates can have different ways they want cases presented. For example, in certain circuits, the agency briefs first. Having standard ways of presenting materials and tightening procedures at the ALJ stage could also help. However, one must keep in mind that the agency believes in a non-adversarial process, so certain things will not be changed. For example, a claimant can always submit new evidence, even in federal court.

Meeting with OIG

OIG's mission. The mission of OIG is to conduct independent and objective investigations to ensure the security and integrity of SSA programs and to bring cases to a prosecuting venue as appropriate. Their business plan is to get money back, prosecute, or convict. Referral sources include the public, SSA employees, private entities, law enforcement, and other government agencies. Allegations that OIG receives are assessed on a daily bases. OIG provides reports to SSA, Congress, the US Attorney's Office, local law enforcement, HHS, and local government.

Prosecutorial discretion. Monetary amounts (how much loss there was to the government) determine whether a case is prosecuted. If a case is not prosecuted, fraud loss (overpayments) and civil monetary penalties can be initiated.

Operation Easy Money. In Puerto Rico, doctors and third party facilitators conspired with claimants to fraudulently obtain Social Security disability benefits.

Fraud indicators. Indicators of fraud included: increased allowance rates in Puerto Rico as unemployment increased, an 84% ALJ allowance rate, top 9 of the top 10 zips codes for DI benefits located in Puerto Rico, template medical reports, and a larger percentage of mental disorder claims in Puerto Rico than nationwide (46% vs. 14%).

OIG's investigation. Actions taken included surveillance, ruse interviews, and undercover agents and confidential informants visiting suspected doctors' offices. At the time, there was no Cooperative Disability Investigations (CDI) unit in Puerto Rico and only two OIG agents. Currently, there is a CDI unit and seven agents.

Outcome. The OIG obtained 105 arrests, \$106 million dollars in loss prevention, and \$172 in savings.

Lessons learned from the investigation:

- An audit trail of actions taken is not available in e-view (the electronic disability folder).
- An audit trail for DDS is not available without involvement of DDS personnel.
- Suspension procedures *en masse* had to be developed.
- There is an ongoing review of cases and some claimants could be reinstated. In some cases, the fraudulent evidence was just to guarantee allowance, not the sole reason for the approval.
- Diagnostics and predictive analyses have been developed to identify potential fraud cases in other investigations. Many cases will involve issues such as those involved here— medical conditions that are not as concrete, such as mental impairments and musculoskeletal issues.

Operation Recoil. This case involved NY Police Department and NY Fire Department retirees with service-connected pensions, fraudulently acquiring Social Security Disability benefits. OIG received referrals from the NY DDS. Doctors, lawyers, and facilitators were involved in the fraud. Boilerplate language was used on SSA forms and template reports were submitted. Even if DDS denied the case, the case could be allowed by the ALJ.

Actions taken included:

- NYPD Internal Affairs provided an undercover NYPD retiree
- Eavesdropping application was approved
- Coordination with local law enforcement where claimants had moved
- Facebook subpoenas
- CDRs initiated in bulk

Outcome. The OIG obtained 134 individuals indicted, 105 pleas, and \$23 million ordered in restitution. Civil monetary penalties were instituted for those not indicted. 260 cases are going back to ODAR for review after discarding fraudulent medical evidence.

Possible disability criteria modifications. Two disability rating factors that should be reexamined are the ability to speak the English language and individuals' level of pain.

Budget. For cases of this scope and to continue to effectively investigate fraud, OIG and CDI could use more people. The Fraud Prevention Act of 2015 would provide guaranteed resources, outside budget appropriations.

Predictive analytics. A new Fraud Prevention Unit has opened in the New York Region and uses predictive analytics. The ability to search cases by attorney and non-attorney representatives

would be useful. In addition, there is a new Office of Anti-Fraud Programs in headquarters; however, investigations should be kept at the local level. Analytics could be done in HQ, but the cases should then be sent to the local region to be worked. Keeping it local will keep the investment of local SSA personnel. In addition, local investigators are more familiar with the area and culture of the people they are investigating.

Meeting with Field Office Staff

Hours. Field office staff discouraged the idea of lengthening hours because of the work that needs to occur on the back end.

Staffing flexibility. Staff stated that budgeting should be more flexible so that managers can assign correctly-qualified people to perform certain work. Staff said it had overqualified people answering phones because staff did not match need.

Systems. Staff stated that certain applications should be developed online such as SSI and overpayments. They wanted an integrated system to perform this work that would avoid error-prone manual calculations. They also wanted data match with passport control to prevent overpayments.

Languages. Staff stated that technology is dated and interpreters are of mixed quality. They felt online explanations in other languages could be better. The SSI wage reporting phone number does not work in other languages or with an accent. Beneficiaries should be able to key in wage information, rather than using voice recognition.

Telework. Some employees would prefer to telework to avoid commutes. Others like going into work.

Holding out. SSI regulation to monitor holding out is difficult to enforce.

SSI paper applications. SSI paper applications for parents of SSI kids take a long time to complete.

Card center impact. Employees felt that the card center reduced waiting in the field office and allowed employees to specialize in particular areas.

Meeting with South Brooklyn Legal Services (SBLS)

Vulnerable clientele. SBLS explained that their clients are below 200% of the poverty level, many with mental illnesses, most are illiterate, and most are not computer literate.

Program burdens. SBLS stated that most problems that clients have with SSA are post-entitlement: living arrangements, savings, income, overpayments, and notices. They noted that significant administrative resources are spent monitoring small benefit amounts.

SSI suggestions. SBLS stated that Congress should raise the SSI asset and income limits and

disregard certain categories of assets such as personal injury settlement money. SBLs estimated that even a minor increase in the asset limit would greatly reduce the number of complications created by beneficiaries who exceed the limit since few manage to significantly exceed the current limit. The current limit creates a disincentive to work or save.

IRS crosschecking. SBLs suggested that if SSA checked income levels of SSI recipients more frequently, they could cut down on overpayments and reduce the difficulty of proving income levels from previous years. SBLs estimate that approximately half of their work relates to overpayments from work income.

Work incentives. SBLs stated that work incentives are too complicated and many SSI recipients would attempt work if the rules were not so complicated and they were not in danger of losing benefits.

Meeting with MetLife

Disability definitions. MetLife defines disability multiple ways depending on the type of plan, but functional assessment is the primary component. For short-term disability policies, disability depends on ability to perform current occupation. For long-term, it starts as the ability to perform a suitable job based on education and experience and then later becomes ability to perform any job.

Assessment. MetLife does not perform medical exams – just reviews medical records. A case manager is assigned to each applicant and they call and set expectations for the applicant. LTD approval is made during STD period to ensure no lapse in benefits.

Contract length. Most contracts pay to age 65. They are normally offset by SSDI benefits which the beneficiary may be required to apply for.

Assessing return-to-work potential. MetLife categorizes claims depending on potential to return to work. They spend more money on return to work efforts if higher likelihood of return.

Wellness programs. Wellness programs can reduce costs 2-5%, reflected in pricing. Most of the national account programs have them. Big companies have them.

Determining costs. MetLife prices their products by looking at claims in the last three years. If no data, they look at previous costs or industry costs. The average LTD benefit is \$2500/month.

Claims paths. MetLife sets four claim paths based on clinical involvement of disability expected, severity of condition, and level of complexity. For example, if a claimant is deemed as “variable return to work,” the case manager will: identify the claim tier, utilize the correct clinical interaction, set appropriate follow up actions, be proactive, set expectations, clearly document the claim, provide exceptional customer service, and safe and timely return to work.

Returning-to-work. LTD beneficiaries return to work about 30-40% of the time. There is a large variation based on the type of claim. Return to work after 10 years is about zero. Between

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6-12 months, return to work is about 2-4%/month. It is important to spend money on fresher claims.

Processing time. MetLife makes its initial decision on STD claims within 10 business days for 80-90% of applications and within 45 days for LTD applications. To do this, MetLife doggedly pursues medical providers to ensure they receive medical records.

Incentives. MetLife seeks to engage claimants to inform them of return-to-work supports that will get them off benefits and back to work. They have supports in place to allow beneficiaries to test returning to work before removing benefits.

Sharing data. MetLife discussed opportunities for SSA and MetLife to share data that would be beneficial for both. For instance, MetLife could report suspected fraud and SSA could share benefit receipt. The Board stated it would like to receive data MetLife could provide on return-to-work statistics.

Judgment call cases. MetLife stated that they follow a consistent process to create as much consistency as possible in their evaluations. MetLife explained that they continually audit and review assessments to ensure consistency and mitigate subjectivity.

Technology. MetLife has developed a disability claim system with an avatar that helps people file online. Their medical records are all online or scanned.

Training. MetLife stated that it takes their claims adjudicators about 18 months - 24 months to act independently on claims analysis.