REPORT IN SUPPORT OF RECOMMENDATION 73-3

QUALITY ASSURANCE SYSTEMS IN THE ADJUDICATION OF CLAIMS OF ENTITLEMENT TO BENEFITS OR COMPENSATION

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Introduction

No attempt has been made to study the claims adjudication process in every benefit and compensation program that is federally financed or administered. However, a number of such programs, social security disability benefits, veterans' pensions and compensation, the Federal Employees' Compensation Act program, the Longshoremen and Harbor Workers' Compensation Act program, civil service disability retirement benefits and federally funded categorical public assistance programs, have been reviewed in some detail. The proposals and discussion which follow reflect general principles which are thought applicable to all of these somewhat disparate benefit and compensation systems. A solicitation of views from agencies administering other benefit and compensation programs has not produced any comment which casts doubt on the ability to generalize from the group of programs studied. A short description of the adjudication process and current statistical quality assurance practices in the programs studied is appended to this report.

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Part I: Positive caseload management should be recognized as essential to the accurate, timely and fair adjudication of claims of entitlement to benefits or compensation. A positive caseload management system should include three connected operations: (1) The development of standards and methods for measuring the accuracy, timeliness and fairness of agency adjudications; (2) the continuous evaluation of agency adjudications through the application of those standards and methods; and (3) the use of the information gathered in the course of such evaluation to identify needed improvements in adjudicative performance.

DISCUSSION

Coverage. (a.) A "claim of entitlement" includes a claim under any program in which the benefit or compensation sought by the claimant is one which is required to be made available to him on the satisfaction of certain statutory criteria. For example, a claim for OASDI benefits would be covered by the recommendation; but a request by a small business for a favorable exercise of discretion concerning its loan application would not be covered, nor would an application for a research grant from the National Institute of Health. The administration of discretionary grant or benefit programs having reasonably well articulated standards for judgment might well be improved by the adoption of some of the techniques suggested in the recommendation. However, because the obligation of positive caseload management is grounded at least in part in notions of agency responsibility to provide assistance to parties making claims of legal right, discretionary determinations have not been included.

(b.) "Benefits or compensation" includes any benefit or any compensation for injury, whether in money or in kind, which is made available out of federal funds or with respect to which a federal agency has assumed the responsibility for determining the validity of claims to entitlement. Public welfare programs, social insurance programs, employee pension plans and workmen's compensation payments are all within the reach of the recommendation to the extent that federal funds or federal administration is involved.

Although it is conceivable that the federal government might fund a non-discretionary benefit program through grants without providing the administering agency with the authority to condition those grants on the use of proper methods of administration in making benefits determinations, no such program

presently exists. Hence, the agencies administering federal grant-in-aid programs in support of benefit programs involving claims of entitlement are covered by this recommendation, along with agencies directly administering benefit programs involving federal funds and agencies making claim determinations involving the liability of third parties for benefits or compensation.

(c.) An "adjudication" is any determination allowing or disallowing a claim to benefits or compensation. Allowances or disallowances at all levels of the claims processing system are meant to be included, whether or not the determination made is entered after opportunity for a hearing.

Rationale. Positive caseload management in benefit and compensation programs might be viewed as the management side of constitutional or statutory "due process." Procedural safeguards whatever their source are designed to ensure an appropriate opportunity for affected parties to put relevant facts and arguments before authoritative decision-makers. "Fairness" to the litigant or claimant is generally taken to be the principal value served by procedural devices such as specific notice of issues or the opportunity to produce evidence, to argue orally and to confront and cross-examine the adverse witness or the right to appeal adverse determinations. These procedural safeguards obviously also serve other closely associated ends such as promoting the correct finding of facts and the appropriate application of law to fact. Adjudicatory systems for the finding of facts and for the authoritative application of law to fact, which contain adequate procedural safeguards and appellate checks, are thus often thought of as self-correcting mechanisms for the fair and accurate resolution of legal disputes or the determination of legal rights or status.

In an adversary judicial proceeding involving claims of private right, which tends to be the archetype of adjudicatory due process, reliance on procedural safeguards and litigant initiative as the guardians of fairness and accuracy is generally sensible. There are problems to be sure in designing systems in which fair opportunity to contest does not result in an equally fair opportunity to obfuscate and to delay. And the solution of these difficulties has focused traditionally on adjustments in the procedural or evidentiary system, the adjective law governing the process of adjudication. However, even with respect to judicial determination of private claims there has been some movement away from reform of adjective law as the means of assuring accurate, fair and timely adjudication. This movement is evidenced by an

increasing concern in recent years with the development of techniques of judicial administration which might make the process of adjudication more efficient, and by an increasing willingness to view the adjudication process as one in which the positive management of cases and case flow to achieve accurate and fair results is an appropriate role for the adjudicator. See, *e.g.*, Jones, ed., THE COURTS, THE PUBLIC AND THE LAW EXPLOSION (1965); Hufstedler, *New Blocks for Old Pyramids: Reshaping the Judicial System*, 44 U. So. Calif. L. Rev. 901 (1971). The fundamental premise of this recommendation is that a posture of positive management of the adjudicatory process to ensure quality is not only appropriate, as in the judicial system, but essential in programs where the administrative adjudication of claims to benefits or compensation is involved.

Perhaps the most general consideration which supports a positive caseload management policy is the attenuation of the adversary context in the administration of programs involving benefits and compensation. The adjudication of claims in such programs is a part of a positive legislative program to insure or protect the claimant against certain economic hazards. This is obvious in benefit programs such as disability insurance or public assistance or veterans' compensation—programs in which public funds are expended. Claims adjudication is the means by which the public interest in providing the benefit is conjoined with the claimant's desire to receive it. While agencies may have some interest in fund protection and in avoiding erroneous payments, they are also charged with the public duty of paying qualified claimants. The claims adjudicator's role, whether at the initial consideration of a completed claim file or after oral hearing, is essentially the same, to provide benefits to eligible individuals. In large measure this function is discharged through nonadversary and informal procedures. No one acts specifically as the representative of the government, and the claimant is usually unrepresented and often uninformed concerning the details of proving up his eligibility. In this context the model of the passive adjudicator ruling on the basis of facts and arguments presented by opposing parties is not appropriate. Agency policy and practice recognize that claims adjudicators must assist to some degree in the development of facts, as well as sit in judgment on evidence presented to them, in order to comply with the agencies' general responsibility for proper administration of the law.

HEW's Handbook of Public Welfare Assistance reflects the position of most benefit determining agencies:

> Relying on the individual as a primary source of information does not relieve the agency of the responsibility to recognize the differing capacities of applicants and recipients to discharge their responsibilities to the agency. Some can provide or obtain needed information after the agency explains what information is needed; others will need specific directions to sources of information; others may want, or have to rely on, the agency to obtain the information for them. (Part IV, § 2400).

Compensation programs such as Longshoremen and Harbor Workers' Compensation or Federal Employees' Compensation involve a higher degree of adversariness. But again adversary procedure is tempered by responsiveness to the basic purpose of these programs—the provision of prompt aid to covered employees—a purpose which the fault system and judicial due process failed to serve adequately. Students of workmen's compensation tend to agree that the extent to which the beneficent purposes of the compensation scheme are realized depends in large degree upon the extent to which the agency assists in the development and settlement of claims prior to a contentious hearing. *Report of National Commission on State Workmen's Compensation Laws,* Chapter 6, 99–114 (1972). Indeed, in FECA cases, while compensation payments are charged against agency budgets, the contested claim is very rare. And in the Longshoremen's program, potentially the most adversary of the federally funded or administered benefit or compensation programs, ninety percent of the cases are disposed of prior to hearing.

In short the promotion of accuracy and fairness which results from adversary contests surrounded by procedural safeguards is largely absent from benefit and compensation programs. Nor is it desirable that contentious procedure be introduced. Many programs deal with huge volumes of claims and a large percentage of those claims are not complex or difficult. A contentious procedure at initial processing levels would almost certainly introduce inordinate delay. Moreover, benefit and compensation claimants are often the aged, the infirm, children and other dependent segments of the population. Reversion to a system which put the full burden for making his case on the claimant would hardly be a contribution to fairness or accuracy in claims adjudication. Even when the claimant is exercising appeal or de novo hearing rights after an initial denial of his claim in whole or in part, programs involving the payment of public funds employ a nonadversary procedure in which the government is not specially represented and an obligation to aid the claimant in presenting his case is still recognized. See, *e.g.,* Dixon, *The Welfare State and Mass Justice: A Warning from the Social Security Disability*

Program, 1972 Duke L. J. 681, 694–95. In this context, accuracy and fairness in adjudication should be promoted through process controls other than, or at least in addition to, procedural safeguards.

A possible check on inaccurate or unfair initial adjudications is the appeals process within the administrative adjudication system. And, of course, there is some correction of erroneous determinations by this method. Appeal as a check on the quality of adjudications has some serious deficiencies, however. One is the lack of an appropriate appellant where affirmative action is taken on the claimant's request and payment is to come from government funds. Unless the claimant disagrees with the amount of the award no appeal will be taken, and in some programs initial decisions are positive, that is result in an award to the claimant, in 90+% of the cases. Even where the decision is negative, appeals are highly and mysteriously selective. For example, in 1970 nearly one-half of the claims for social security disability payments (excluding technical denials) were rejected. From this universe of denied applicants about eleven percent requested a hearing. (The figures from which these rough computations were made are reported in Dixon, *supra.*) My attempt to figure the appeal rate in public assistance programs from various statistical reports of the National Center for Social Statistics reveals that fair hearing requests were running at only about two percent of potentially appealable determinations during the most recent six-month period for which statistics are available, and 54 percent of those appeals were lodged in three states. (Included in the universe of appealable public assistance decisions were all grants, denials, alterations, and terminations, save terminations due to death, because appeals may be and often are lodged concerning the amount of a grant.)

We simply do not know enough about the self-selection process for appellants to determine how these appeal rates ought to be interpreted. The rates seem quite low, but do they reflect a high degree of claimant satisfaction, a low error rate for initial determinations, poor information about appeal rights or what? Without such information we certainly cannot conclude that the opportunity for appeal is an effective check on the fairness and accuracy of even initial denials of claims for benefits or compensation.

An additional problem with "appeals" as a means for controlling the quality of the agency adjudicative process is that the appeal is often not an appeal on the record of the initial deter-

mination. It is rather a de novo determination on an open record which may be supplemented. Hence, a finding on appeal which diverges from the initial determination on the claim is not necessarily a finding of error. It is merely a different finding which may have been made on quite different facts. For example, in disability adjudications the claimant is often becoming progressively more disabled and hence the initial denial and the award on appeal may both be correct. This indeterminateness renders the results of appellate review of limited utility in evaluating the quality of initial decisions.

Moreover, the process of hearing appeals does not of itself produce information on the timeliness of claims processing or on patterns of problems which may be emerging at the initial levels of adjudication. The orientation of the appeal or hearing process is toward the problems associated with the individual claim or claimant involved in a particular hearing, not toward the quality of the claims process as a whole.

The foregoing remarks should not, of course, be taken as indicating that the procedural safeguards often associated with adversary process and opportunities for appeal have no place in the adjudication of claims of entitlement to benefits or compensation. In certain situations specific hearing rights have been found to be constitutionally required; statutory and regulatory provisions customarily emphasize procedural safeguards and these safeguards are often of great importance to particular claimants. The point is merely that in benefit and compensation programs the obligation to provide fair, accurate and timely determinations can be promoted to only a limited degree by these techniques. In order to fulfill that obligation agencies must go further to develop a positive caseload management system which will assure a high quality adjudicative product. Indeed, most agencies have accepted that general responsibility. This recommendation and discussion merely seeks to provide a conceptual model and to draw out the implications of such a system for use by agencies in improving their performance.

Some general conceptual issues. While the development of any positive caseload management system (hereinafter occasionally PCMS) must reflect the needs and realities of the particular benefit or compensation program involved, some general statements about approaches to such a system may be useful. Specific techniques for collecting, analyzing and utilizing data are discussed more fully under Parts II–IV of the recommendation.

Development of standards and methods for the evaluation of

"accuracy," "timeliness" and "fairness" in adjudication, the first step in positive caseload management, is not a simple matter. To begin with the question of "accuracy," decisions might be said to be accurate if facts are correctly found and an appropriate application of relevant program policy is made to those facts. However, the "correctness" of fact finding and the "appropriateness" of policy application often involve questions of judgment. For example, the apparently simple determination of a claimant's age for purposes of social security retirement benefits may, in the absence of official birth records, involve the weighing of contradictory evidence from numerous sources. Any evaluation of the "correctness" of the adjudicator's ultimate finding of fact with respect to age will thus involve a judgment concerning the soundness of the adjudicator's judgment. In order to make the evaluation of the quality of the adjudication process with respect to accuracy of fact finding more realistic, and hence more meaningful, some refinement of the evaluation beyond the simple notation by an evaluator that an incorrect finding was made may be required. For example, the evaluation review might distinguish between "substantive errors" and "judgment deficiencies." The latter category would cover situations in which a reasonable man might have found as the adjudicator did but the reviewer thinks that a different finding was indicated by the evidence.

A slightly different problem of appropriate methods for determining accuracy involves the question of whether one is interested in correct fact finding on the record that was before the adjudicator or in "correctness" in some more objective sense. To continue the previous social security example, a finding that a claimant is of a particular age may appear correct given the evidence compiled from family sources, but records from public school departments would have contradicted that evidence had they been secured. Record review might classify the determination as correct, whereas a review involving de novo redevelopment of the case would find an error. A PCMS should probably be interested in both types of error, although it may seek to obtain information about them in different ways.

For example, experience with problems unearthed by reviews involving a complete redevelopment of cases may suggest that the agency instructions to adjudicators be clarified to specify the kind of development effort necessary in identified types of cases. As urged in Part IV of this recommendation quality assurance can thereby become a part of policy and operational control improve-

ment. Record reviews can then be made sensitive to situations involving potential substantive errors. For example, a review of "case development effort" can be made on the basis of the documentation in the claim file and an "error" assigned for failure to include evidence or a notation that evidence was sought from certain predetermined sources. Hence the poorly developed evidence on age in the preceding example might yield not a finding of substantive error, but a finding of a case development "error."

Standards for accuracy, such as permissible errors per hundred cases, are also difficult to develop. Ideally every system should establish minimum levels of adequate performance and goals for optimum adjudicative performance. But how are they to be set? Zero errors can be set as the target, but that goal is unrealistic and hence of limited value as a management tool. A moving target such as the mean or median number of errors per adjudication unit during the previous reporting period can be used to provide feedback on how various districts or regions or, in some cases, individuals stack up against adjudications for the system as a whole. But, of course, it may be that everyone should be doing better. When in this sort of numbers game it is well to remember the aphorism repeated several times by a program analyst interviewed in connection with this report, "Errors are for analysis, not for counting."

"Timeliness" obviously is highly susceptible to mathematical expression, reporting and standard-setting. However, goals or minimum standards of performance have the same problems here as in the area of substantive errors—they are dependent on experience and management purpose. Two additional and somewhat special problems with timeliness evaluation also bear mentioning. The first is the potential for timeliness evaluation to be perceived as oppressive if used to make judgments about individual adjudicators. The second is the potential impact of timeliness evaluation on other adjudicative goals, such as, substantive quality or first-in-first-out processing of claims. These problems are similar to ones recently ventilated in congressional hearings involving claims that Internal Revenue Service agents were evaluated on the amount of deficiencies collected from taxpayers. The first problem can be dealt with by a sensible and sensitive personnel policy and a practice of reporting timeliness data in terms of management units larger than an individual adjudicator. The second problem should be solved by using a PCMS which evaluates both quality and speed and by refining the statistical

analysis of processing time so that it reveals "creaming" of easy cases to meet timeliness goals.

"Fairness" as a separate criterion of system performance is somewhat redundant with accuracy. If findings of fact are correct and application of policy is appropriate, decisions should be fair. However, we have already mentioned the possible shortcomings of "accuracy" evaluations as a means of determining whether the claimant got that and only that to which he was entitled. With respect to "judgment calls" or PCMS evalutions solely on the basis of record evidence, situations in which management evaluation and control of accuracy is tenuous, fairness can perhaps only be appraised by an independent evaluation of the "process" elements of adjudication. Treatment of "fairness" as a distinct goal in adjudicating claims and the separate evaluation of fairness through the PCMS tends to promote this focus on process elements. A supplementary check on fairness should thus be directed at those procedures and routines in adjudicating claims which are meant to get the relevant facts, policies and arguments before the adjudicator and to facilitate sound decision-making—things such as notice of issues, case development effort, articulation of the bases for decisions and explanation of opportunities for appeal.

The basic standards of fairness should be quite straightforward—compliance in adjudication with those procedures and routines prescribed by law and by agency policy. Beyond those standards, positive caseload management with fairness as one of its goals implies an attempt to determine the extent to which procedures and routines might be altered to provide higher quality, that is more accurate and/or expeditious, adjudication of claims.

Continuous evaluation with respect to established standards or indicators of quality, the second step in positive caseload management, requires little comment here because questions of evaluation technique will be addressed further in Parts II and III of the Recommendation. However, it may be worthwhile to stress the word "continuous." Because effective management requires the ability to perceive trends in adjudication performance and to relate quality data to program changes and exogenous factors which influence program performance, positive caseload management implies a continuous monitoring function. Merely occasional collection and evaluation of data will not provide the necessary bench marks of performance necessary for effective action, although the periods with respect to which data is collected (month,

quarter, year, irregular intervals) will of course depend upon the program, its resources and the type of information sought.

The utilization of data to improve adjudication quality, the final PCMS operation, involves the exercise of management judgment of two sorts: The first is analysis of why errors or delay occur. The second is what should be done to bring about desired improvements. Part IV of the Recommendation addresses itself to an issue of agency structure which bears on these judgments.

Part II. As part of their positive caseload management program, agencies should begin immediately to explore, develop and implement statistical quality assurance reporting systems that will indicate the accuracy, timeliness and fairness of claims processing. In designing such systems, agencies should consider the need for information of a type that:

a) Reflects differences in the types of cases and types of issues adjudicated and the stages of the administrative process involved;

b) Identifies the management unit or, where appropriate, the individual adjudicator involved in order that effective action may be taken to reinforce success and to improve performance;

c) Permits separate evaluation of (1) substantive decision-making, (2) case development effort and (3) procedural regularity;

*d) Enables separate evaluation of particular functions of the decision process (*e.g., *issue statement or evaluation of evidence in substantive decision-making).*

DISCUSSION

"Statistical quality control" or "statistical quality assurance" is simply the use of statistical techniques, which may involve sampling, to compile data on the indicators of quality that have been determined to be relevant for a particular program. Where they may appropriately be employed, the use of sampling techniques has a number of positive effects on positive caseload management: (1) It reduces the costs of monitoring quality on a continuous basis. (2) It tends to force a concentration in important caseload management concerns, *e.g.*, the delineation of the distinct elements of the adjudication process and the analysis of their contribution to high quality end products. (The purpose of statistical sampling is necessarily analysis and evaluation as

a basis for process improvement, a purpose which may be considered of secondary importance when an agency reviews 100% of its initial decisions for correctness.) (3) The assembly of sample data produces a patterned feedback on the types of errors which are being made and permits the agency to distinguish random, and essentially uncontrollable error, from recurrent errors of a similar type or by the same adjudication unit which can be brought under control.

Obviously the more detailed the data provided by a statistical quality assurance reporting system, the more useful it will be in pinpointing problems and suggesting reasons for their existence. The sub-parts of Part II of the Recommendation suggest a series of ways in which data might be collected to promote analysis and resolution of adjudication problems. Some, but not all, of the suggested types of information is collected by each of the existing statistical quality control programs described in the Appendix to this Report. Data collection practices must, of course, be tailored to individual programs, but the suggestions made embody what are taken to be sensible practices that should be followed where practicable.

a) The suggestion here is quite straightforward. By "types of cases" one might mean simply to what program the claim relates. The Bureau of Hearings and Appeals in the Social Security Administration, for example, processes retirement and survivors insurance cases, disability cases, and Medicare cases and has processed black lung benefit claims. In order for its statistical data to reveal anything useful, compartmentalization by program is required. However, agencies should go considerably further in devising useful case categories. To continue the same example, BHA collects timeliness data which reveals whether the case was dismissed for technical reasons, involved a claimant-initiated postponement, was a "no-hearing" case, or was a case in which agency development was required. This data gives the agency a better idea of how its information on timeliness within a general category of claims should be evaluated, because it knows something about the contribution of dismissals, claimant postponement of hearings, the hearing itself and agency development of cases to processing time.

By "types of issues" is meant the specific statutory or regulatory criteria and the factual issues involved in determinations. For example, the Veterans' Administration breaks issues down into two major categories—rating of disability and payments authorization. Within "disability rating" issues may be further

divided into determinations of whether the disability is service connected and the determination of the appropriate extent of disability from the rating schedule. And of course these issues may be further subdivided into sub-issues which respond to the criteria for service connection and the evaluation of the extent of disability. Obviously a notation that an error involves an "incorrect application of the rating schedule" is considerably more meaningful for management purposes than a simple notation that the case contains an error. Information that the case was a "back case" or a "nervous disorder" is even more useful in identifying the source of the problem. A pattern of similar errors would suggest, for example, that there is a need for improvement in the schedule or in the instructions for its use.

Detailed information can, of course, begin to overwhelm administrators and to impede management rather than aid it. One solution to this problem is to reduce detail as information is reported up through the supervisory system. The immediate supervisor of an adjudication unit in a district office needs and can manage much more detailed information than the bureau or administration director in the central office.

By "stages of the administrative process" is meant simply a breakdown into categories such as initial decisions, decisions on reconsideration, decisions on continuing eligibility, decisions on appeal and so on.

b) Obviously corrective or reinforcing action cannot be taken unless the supervisory staff knows where to direct its interest. Normally, sampling will not produce reliable information on individuals, and hence it can be used only to evaluate units, such as a regional or district office, which produce a large number of decisions. However, most statistical quality asurance (hereinafter occasionally "SQA") evaluation routines should also include the return of sample files for redetermination when errors show up in the SQA review. There is certainly value in having errors brought to the attention of individual adjudicators when files are returned, and hence information concerning who made the erroneous decision should be available. Moreover, at some levels of the claims process, for example appeals boards, the review sample may be 100% of the decisions. Here compilation of individual adjudicator performance is clearly reliable and appropriate.

The approach to the correction of error on the reinforcement of high quality adjudication effort will, of course, vary from program to program. In some instances administrative law judges

are the adjudicators and their impartiality must be protected. In others, state personnel are involved in administering programs which are in whole or in part federally funded.

c) While the major interest of program management is the timeliness, accuracy and fairness of substantive decisions, two aspects of the decision process—procedural regularity and agency case development effort—may be singled out as requiring specific attention in an adequate statistical quality assurance system. Obviously both procedural regularity and case development effort bear on the accuracy and timeliness of substantive decision. Accurate, and hence in one sense "fair," decisions may occur on the basis of inadequate case development and irregular procedure; but such lapses certainly do not promote the goals of substantive accuracy. Moreover, poor development and procedural irregularity may produce claims records which support the "accuracy" of judgments which would be considered inaccurate were the record more complete. As previously noted, this, appearance of "accuracy" may be reflected in a quality assurance review based on the record. Thus lapses in the decision process may not only produce error but also effectively hide it. Perhaps more importantly, procedural regularity and claims development effort have a special relevance to the actual and perceived fairness of adjudications. A consistent high quality in adjudication procedures and in agency case development effort is imperative if like cases are to be revealed, perceived and treated as alike. Hence, it would seem necessary to collect data on both of these elements of the decision process in any statistical quality assurance program which treats fairness as a program goal in the adjudication of claims.

d) Analysis in terms of functions is a means for making more specific the evaluation of substantive decision-making, case development and procedural regularity. Each of these aspects of claims adjudication can be broken down into the operations that should be carried out by adjudicatory staff. Under case development, for example, the operations might be broken down into items such as collecting medical records, obtaining vocational evidence, scheduling necessary medical examinations, appropriate follow-up action and so on. The possibilities for further calibration are virtually endless and obviously require the exercise of management judgment concerning what level of detail in quality assurance information is worth the cost of collecting it.

Part III. Agencies should employ such other techniques for gathering information on their adjudication process, including field investigations and special studies, as are required for the evaluation of accuracy, timeliness and fairness. Agencies should be particularly sensitive to the need for better information on the extent to which claimants' personal resources, social status and access to representation or other assistance may affect the adjudication of claims.

DISCUSSION

A well-designed statistical quality assurance system can provide a continuous flow of information concerning the quality of adjudications. However, it cannot provide all the information necessary for effective management of the adjudication process. For one thing the data collected by such sampling techniques must often be computer assembled. Hence, the information must be limited to that which is easily codable. This is likely to produce tabulations of the incidence of error but little information on the causes of errors. Hence, the SQA system often merely alerts the agency to apparent problems which must be investigated further in order to determine whether the problem is real and what should be done about it.

Moreover, the reliability of sample data decreases with the size of the sample, or perhaps more accurately, potential variation of the sampled universe from the information provided by a particular sample increases as sample size declines. Hence, information derived from a sample that is drawn to be highly reliable concerning a regional office may be quite unreliable with respect to a particular adjudication unit within that region. For example, statistical quality control data on state public assistance determinations may be reliable for the state as a whole, but it tells one very little about individual county welfare offices who do the actual adjudications. Behind the error rate for the state might lie some county offices which have nearly perfect performance and others whose record is disastrous. Periodic audits or field reviews which deal with smaller adjudication units in depth must be used along with statistical quality control procedures to provide adequate information for proper oversight of the adjudication process.

SQA data may be seriously deficient concerning other problems of considerable moment in the provision of timely, fair and accurate adjudication of claims. For example, when the SQA data is compiled by reviewing case files there is no independent

check on whether the information in the file reflects the true facts. And, in large programs it may be much too expensive to conduct SQA reviews other than by analysis of the files. Hence, without additional quality assurance effort and application of agency processes, policies and case development routines may be producing errors which never show up. These sort of errors can only be found and dealt with by reviews which redevelop cases *ab initio.*

One such approach is the Social Security Administration's Evaluation and Measurement System which is designed to validate its claims policies and procedures. Each month 1,000 recently completed adjudications are assigned to specially trained personnel who redevelop the claims and who seek out the best available evidence on every issue involved in eligibility. These determinations are then compared with the initial, routine decisions to see if any significant differences appear. If so, that is an indication that an investigation should be made into means by which the reality as determined by the usual claims process might be made more consonant with "objective" reality as determined by the much more intensive redevelopment.

A similar type of issue that should be of concern to agencies is the question of whether inaccuracies, unfairness and tardiness are randomly distributed among claimants. Although agencies accept a responsibility for assisting in claims development, there is nevertheless some considerable reliance placed on claimant initiation and development of claims in all benefit and compensation systems. Hence one might wonder about the extent to which agency assistance in developing claims neutralizes factors such as the claimant's educational level or access to independent technical resources (lawyers, physicians, etc.). Are those who are less well-endowed personally and financially, or perhaps those who are the objects of social prejudice, at a disadvantage in the claims process? Because the information necessary for statistical correlations which would begin to answer these questions is not routinely collected in case files, SQA reviews are not good vehicles for getting at the answers. Nor could all of the requisite information be routinely collected when processing cases without suggesting to claimants that facts which are not relevant to the adjudication of claims are indeed relevant. The only technique for analyzing this aspect of adjudication quality is the special study.

Part IV. The positive caseload management program should facilitate not only objective evaluation of the agency's processing operations, but also the effective utilization of quality assurance information in policy formation and operational control.

There are two major requisites for a successful quality assurance program. The first is that the collection of information on the quality of adjudications not be subject to the control of the adjudicators whose product is being evaluated. The second is that the information be developed in such a way that it is useful to and used by those in charge of adjudication in improving adjudication performance. These considerations suggest that considerable care must be taken to ensure the independence of the quality assurance staff without pushing them into a detached position in the agency from which they, and their evaluations, have no influence on policy.

Perhaps two principles might be of some use in dealing with this structural problem. The first is that while measurements or data collection must be done through procedures which will assure independence from those responsible for adjudication, the development of policy concerning what information will be collected and the interpretation of results must be carried out in connection with those who have the adjudication responsibility. A second is that the evaluator should always report his findings at least one supervisory level above the level whose performance he is evaluating, although, of course, the information should also be made available to the evaluated unit as well. Unless both of these principles are observed evaluation may be unsound or irrelevant and sound and relevant analysis may go unheeded.

The structure of the quality assurance program in the Bureau of Disability Insurance in the Social Security Administration again provides an attractive model. Statistical quality assurance reviewers in the Bureau are independent of the line adjudicative staff and have no adjudicative responsibilities. Sampling is done in a fashion which effectively camouflages the cases that will be drawn for review. And questions of policy on what data is to be collected, what standards are to be set for the various quality criteria and what action is to be taken on the basis of information revealed by SQA reviews are committed to a Quality Assurance Council composed of the representatives of the five major divisions in BDI, including Quality Assurance. Validation of the Bureau's policies through the Evaluation and Measurement Sys-

tem is committed to a separate staff in the Office of Research and Statistics which reports directly to the Commissioner.

Although this recommendation does not purport to deal with the range of devices which might be employed to deal with discovered defects in the adjudication process, it is perhaps worth mentioning that the available alternatives include both major policy change and doing nothing. Intermediate responses might include increased training, better policy definition, the institution of special checks on troublesome types of cases, or the provision of increased technical resources to adjudicators or claimants. Because effective action to make the adjudication of claims fairer, more accurate and more expeditious is directed to systemic problems rather than individual errors and depends ultimately upon the will of the agency to act, the management side of due process can never wholly supplant the need for the more traditional protection of procedural safeguards, and appellate review.

APPENDIX

Descriptive Appendix on Statistical Quality Control in Selected Programs Involving the Adjudication of Claims of Entitlement to Benefits or Compensation

I. Social Security Disability* Insurance

The Social Security disability program has a rather complex decisional process, involving determinations by state agencies, four levels of decision-making at the federal level, and judicial review in the federal district courts. At the initial determination stage, a state agency team makes a recommended decision which is reviewed on a sample basis by the Bureau of Disability Insurance (BDI) central office in Baltimore. No hearing is held. The decisions are based on written medical reports from the claimant's physicians and, if requested by the state agency, examination reports from private consulting physicians.

Dissatisfied claimants receive a reconsideration, upon request, in which the initial process is repeated except that BDI reviews every state reconsideration decision and not just a sample. At the third stage a formal hearing is available, on a "de novo" basis, before an Administrative Law Judge (ALJ). Those dissatisfied with the ALJ's decision may appeal to the Appeals Council, which has, however, a discretionary jurisdiction. The Council can also initiate appeals on its own motion and decide questions certified to it by ALJs. It functions in two-member panels, and can change a decision on the basis of error or new evidence. Neither the decisions of the Administrative Law Judges nor the Appeals Council have precedential value. The last level of appeal is for a claimant to bring a suit in the federal district courts. The court's decisions can be appealed through the federal appellate courts by claimants or the government.

A. *Initial Decisions by State Agencies*

Until recently the Bureau of Disability Insurance received all the determinations made by state examining teams. The BDI examiners were allowed to reverse awards and to send the question back to the state agencies (SA) when they disagreed with a denial. BDI has replaced this system with a system of statistical quality control involving SA sampling and review of its own product and a BDI review of 5% of the SA's cases.

In carrying out its review function each SA must take a sample of its cases in each month of a size specified by BDI. These cases are reviewed by specially trained "quality assurance" personnel in accordance with a basic format prescribed by BDI and any further factors the state wishes to have reviewed. The review has three major categories: (1) how well the case is documented and developed, (2) the correctness of the decision and its justification by application of the relevant decision rules, (3) technical questions, such as routing, but including claimant notification. Within each

* The statistical quality assurance system for the Retirement and Survivors Insurance program under the Social Security Act is very similar to that used in the disability program and will not be separately treated.

of these categories there is a series of questions and the reviewer is to answer "yes," "no" or "N/A." "No" responses are equivalent to finding an error.

Each review question is coded and by application of the code the SA can cumulate review sheets into a monthly report showing the level of errors for each type of claim processing function. This error level can then be correlated with other coded information about the reviewed claims, *e.g.*, race, sex, age and education of the claimant; claims examiner; type of claim; type of disability (muscular, cardiovascular, etc.); processing time; decision result and whether the decision was an initial or reconsidered decision. Properly interpreted these correlations will suggest areas of strength and weakness in the SA adjudication process and hopefully lead to program action to make improvements.

BDI's 5% sample review follows pretty much the same format. Hence it is a check on the SA's performance and on the SA's quality assurance program. The Bureau can also use its review to produce special sorts of information for policy formation purposes. For example, a portion of the 5% sample are given an intensive review with respect to medical determinations in order to develop data on the incidence of agreement among physicians concerning physical conditions which are totally disabling. At a certain level of agreement a condition may be added to the regulatory listing of *per se* disabilities.

There are currently no standards for errors which indicate a system out of control. The present BDI strategy is threefold: (1) let the system generate some data on the basis of which national operating averages can be established; (2) push for improvements in the below average systems and thereby continuously upgrade the norms; (3) get the QA personnel established in positions of influence in the SA's.

The questions of policy on what data is to be collected, how the data generated is to be manipulated, what norms are to be set and what policy action taken based on the information revealed are committed to the Quality Assurance Council. That Council is made up of representatives of the five divisions within BDI. This is an entity with the dual purpose of assuring (1) that the QA information gets to the people who can take action and (2) that the control of the program does not slip into the grasp of the statisticians.

B. *Hearing Level*

There is some consistent statistical record keeping on the decisions of Administrative Law Judges (ALJ). The Bureau of Hearings and Appeals (BHA) of the Social Security Administration will know, for example, the work product per month of each ALJ, the rate at which he "reverses" previous determinations and his average time in processing cases. It can counsel the ALJ on methods of improving his efficiency if problems concerning productivity and timeliness show up. The question of the quality of his product which may be reflected in an "abnormal" "reversal rate" are more difficult.

Technical errors, such as failure to establish the time of the onset of disability in an allowed claim, can be sent back to the ALJ by the Liaison and Survey Branch of BHA's Division of Field Operations. Where the problem is one of poor development or questionable judgment, review is simply by the appellate process within BHA at the behest of the claimant or on a recommendation for "own motion review" by an Appeals Council Examiner. These examiners supposedly have a good idea from experience about which ALJ's are likely to be unreliable and their product is checked more carefully.

However, there is no stylized review as in a SQA system to produce data on the patterns of problems and the only feedback to the ALJ is through Appeals Council reversal of his decisions.

C. *Other Levels of Adjudication*

The SQA system will very shortly be made applicable to the second level of disability determination—decisions on reconsideration—and to decisions on the continuation of disability benefits. A larger sample, 8–10% of the decisions, will be drawn from these adjudications; BDI will continue to review 100% of certain types of cases in which differences of viewpoint most frequently occur, such as neurological and musculoskeletal cases.

There also are plans in other bureaus of the Social Security Administration to institute a SQA system for the actions of district office personnel, who screen out some cases because of lack of the necessary attachments to the social security system and who aid in the development of the claim file for submission to the State Agency for initial decision.

II. Veterans' Compensation and Pension Benefits

This, the largest federal disability program, has only two administrative decisional stages and no court review. At the initial level in the VA regional office the important eligibility question—the application of the rating schedule and the determination of service-connection—is made by a Rating Board consisting of one doctor and two legal specialists. Case development work is done for the Rating Boards by other regional office personnel. Informal hearings are available. In difficult cases a VA doctor makes an examination and submits a report to the Board. Most claimants are represented by one of the veterans' service organizations, which have free offices and equipment in the Va building. Non-unanimous Rating Board decisions are referred to the supervisor. If a Rating Board wishes to allow a case not permitted under the rating schedule, because of exceptional circumstances, the case must be referred to the VA central office in Washington.

Initial decisions can be appealed to the independent Board of Veterans' Appeals (BVA). When an appeal is filed, the initial level decision-makers review the file to prepare a statement of the case ("SOC") explaining the decision, and in the course of this may allow the case. The statement of the case is sent to the claimant, and if he fails to respond to it, the case is closed. Only one-half the cases in which initial appeals are filed become "formal appeals," largely because the applicant fails to respond to the SOC. Thus, this SOC process includes some of the functions performed in the reconsideration stage at other agencies.

In cases formally appealed, BVA gives de novo consideration and an opportunity for oral evidentiary hearings. BVA can reverse for error or on the weight of the evidence, the latter basis being used in most cases. The Board operates in three-member panels and by unanimous vote. Non-unanimous cases are referred to the Chairman who can vote with the majority or enlarge the panel. BVA decisions do not have precedential value.

A. *Regional Office Adjudications*

There is a daily "first-line" review of the total work product of most adjudication units (all except those few in which there are not enough VA employees to insure an independent review). A statistical sample of all claims on which any action (initial determination, redetermination, discon-

tinuance, etc.) was taken by the unit on a given day is reviewed for both procedural and substantive correctness. The reviewer corrects any error found, whether it involves the particular action on a claim taken that day (*e.g.*, adding a new dependent to a veteran's file) or any action taken previously which comes to his attention (*e.g.*, the initial determination that a veteran had been honorably discharged and was therefore eligible for benefits). He also enters the numbers and types of errors found into a continuing tally, which is sent at the end of each month to a computer center. At the center the figures are turned into a monthly report on the regional office; the report is then sent both to the national Office of Appraisal and back to the regional office.

The Office of Appraisals monitors these monthly reports, looking for trends, but it does not conduct its own separate statistical review of a region's monthly output. Thus there is no continuing check-up on a region's quality control operation. On an average of once every eighteen months, however, the Office of Appraisal conducts an in-depth review of the *total* operation of a regional station. As part of this review, the Office conducts a random sampling of the station's work product, looking for the same types of errors that the station checked for each day. The findings in the station's monthly quality control reports are then checked against the results of the Central Office's own review. In this way the Office in effect reviews the station's statistical quality control ("SOC") operations. If the variations between results of the Office sample review and the findings expressed in the stations' monthly report is significant statistically, that fact becomes part of the Office's report on the management performance of the regional station.

In addition, the Office sends a report to the unit on each error that it found in the individual cases that it reviewed during its sampling. For any "gross" errors affecting basic entitlement, the Office sends a detailed explanation of how the station went awry, plus instructions on how to correct the mistake.

The theory behind this quality control procedure is that on a continuing basis quality control can best be handled in a decentralized fashion at the regional level; the central office needs to get into the act only periodically, to insure that the product of the daily regional reviews faithfully reflects the true performance of the stations.

The SQC system looks at both "quantitative" and "qualitative" factors in the adjudication process. Quantitatively the system looks at the efficiency of the operation measured in terms of man hours per end product. Standards have been developed through experience against which performance is measured, for example, the standard for adjudicating (that is, time spent by personnel in the adjudication section) an initial disability claim is 2.38 man hours. There are also overall timeliness standards for processing various end products. For initial disability claims the "guidelines" are to process 50% within 60 days, 75% within 90 days and 98% within six months.

The "qualitative" review looks at sample cases and evaluates them for (1) substantive error (errors leading to incorrect result), (2) judgment deficiency (errors in the development of a claim file and cases in which reviewer thinks a different result more tenable than the one reached) and (3) procedural discrepancies (errors which do not affect basic entitlement). Each of these categories is broken down on a standard form into a series of subheadings and specific inquiries. The survey would seem sufficient to give a good "patterned" feedback on where the problems are. Although the way

in which the questions are worded leave a fairly large area of discretion to the reviewer, the system is designed to force agreement on whether an error really existed. Each file with an error notation is sent back to the initial adjudicator who is required to agree or disagree with a finding of error. If there is disagreement, the question goes to a higher agency level for resolution.

For each category of error (substantive, etc.) there is an established "goal" and an established "minimum acceptable level" of errors per 100 cases. For example, the goal in substantive errors by rating boards is 1.5 per 100 cases and the minimum acceptable level of performance is 4.0 errors per 100 cases.

B. *Adjudication by the Board of Veterans' Appeals*

There is a somewhat different quality review system at the Appeals Board level. The Board is divided into a number of Sections and each Section has a staff of attorneys who prepare initial decisions. These decisions are then sent for "revision" to the Section, which also evaluates the quality of the initial decision. This evaluation is made on a standard form which breaks each decision down into a set of component operations (statement of contentions, findings of fact, discussion and evaluation, etc.) and weights them numerically in terms of their importance. A perfect score is 100. Each Section can in this way develop data on the performance of its attorneys and give them help in areas of weakness. The same form is used by a rotating committee of Appeals Board members to evaluate, on a sample basis, the work of each Section of the Board.

III. Civil Service Disability Retirement

The Bureau of Retirement, Disability, and Occupational Health of the Civil Service Commission has three administrative decisional stages and no court review. Initial determinations are made, without a hearing, by Regional Medical Officers (who are M.D.s) on the basis of reports from the claimant's supervisor and personal physician. If needed, a medical examination by a government doctor will be ordered. In the second stage, dissatisfied claimants may obtain a de novo informal hearing from Civil Service Commission appeals examining officers. The last appellate level is the Board of Appeals and Review, which will accept written new evidence but does not give oral evidentiary hearings. The officials of the Board and the appeals examining officers are not doctors, and for each, disability cases are only a minor part of the total caseload.

Because the initial adjudications in this system are made by a single medical officer working alone (save for clerical staff) in one of the six regional offices, there is no means for conducting an independent quality review at the regional office level. All sampling is done by the national office. The interest in the national office review is clearly the employee's interest. 100% of all denials and agency initiated claims are reviewed, while the awards are reviewed on a 10% sample. (Indeed until recently the regional medical officers had no authority to deny claims without central office approval.)

The files selected for review are analyzed by the national office on two broad bases—whether the decision is substantially correct and whether the claim is adequately developed. If the claim was agency initiated and there-

fore comparable to an adverse action, there is also a detailed review for procedural regularity. The analyst writes a narrative report of his finding which is sent to the Regional Medical Officer ("RMO") should the analyst conclude that a finding was improper. The national office cannot reverse or remand the case to the RMO except through the appeals process.

Statistical analysis is currently limited to (1) the number of cases decided by each Regional Medical Officer and (2) the ratio of awards to denials and the ratio of total to partial disability findings by each RMO. The analysts also look for cyclical variations in an individual RMO's decisions and at the extent to which his denials are reversed on appeal. If a particular medical officer's product varies substantially from the norm, or in relation to his own pattern of prior performance, the agency is put on notice to inquire further into the situation.

A new coding system is being introduced which should allow the Bureau to begin to correlate types of diseases or injuries with claims determinations sometime during the next year. The Bureau is also about to publish its first new Handbook for Regional Medical Officers since the mid 1950s.

IV. Federal Employees' Compensation Act

The Office of Federal Employees' Compensation in the Department of Labor ("OFEC") has an administrative structure similar to that of the Civil Service Commission in that it has three stages and no court review. Initial level decisions are made by lay claims examiners, however, and reconsiderations, with informal hearings, are provided by the separate Division of Hearings and Review within the OFEC central office rather than by an independent office. The reconsideration personnel and the ultimate appellate body, the Employees Compensation Appeals Board ("ECAB"), handle only FECA cases. The ECAB decisions are published, have precedential value and are circulated to the lower level decision-makers. Medical advice is given to decision-makers by OFEC-employed doctors. If there is a conflict between the medical report filed by the claimant's physician and that done by the government physician who examined the employee at the time of his injury, the case is referred to a randomly chosen private specialist for his opinion.

The Office of Federal Employee Compensation does not use a statistical quality control system in the management of the Federal Employee Compensation program. OFEC does have a quite impressive list of instructions, reviews and delegation procedures designed to maintain a high quality product, however, and these management tools and appellate processes doubtless prevent many decision errors in areas where experience has shown there to be a potential for variance. However, one may wonder whether as the program grows these procedures will provide the sort of systematic information that is needed for effective caseload management.

The OFEC yearly audits of the ten regional offices seem to be moving in the direction of a uniform reporting system. The auditors have a list of questions to which they should address themselves in their management reviews and their review of a sample of case files. However, the inquiry and reporting of audits would have to be standardized to a much greater degree before they approached a point at which reliable data on trends might be produced or quasi-objective standards for timeliness or adjudication quality could be employed. There are, of course, costs in moving toward objectivity,

but the implementation of more rigorous and uniform evaluation procedures does not require that they be substituted for the current audit process. Standardized and hand-tailored quality reviews may be made mutually reinforcing.

V. Longshoremen and Harbor Workers Compensation Act

Most compensation claims are settled without agency action by agreement between the claimant and the insurance company which provides compensation insurance to the worker's employer. If a dispute arises between the parties, the federal agency—the Office of Workmen's Compensation Programs in the Department of Labor ("OWCP")—through its deputy commissioners first acts as a mediator, scheduling informal conferences to encourage negotiations and settlement by the parties. Prior to the Longshoremen's and Harbor Workers' Compensation Act Amendments of 1972 cases in which settlement could not be achieved were tried at an informal evidentiary hearing before a deputy commissioner, with the carrier and claimant participating as adversaries. There was no administrative appeal from the deputy commissioner's decision; a dissatisfied party's remedy was by review in a federal district court. Under the 1972 amendments and their implementing regulations deputy commissioners retain their mediation function at pre-hearing conferences, but hearings are now subject to the formal requirements of the APA and are before Administrative Law Judges. A new Benefits Review Board has been created to hear appeals from ALJ decisions. Final orders of the Benefits Review Board may be appealed to a circuit court.

There is no statistical quality control system in the L&HWCA program. Again there are certain management checks on decisions which might produce abuses, *e.g.*, lump sum settlements, or withdrawals of claims. Records are kept on the efficiency and timeliness of claims examiners' processing of claims which go to hearing. The data collected enables OWCP to check into apparent problems of delay, excessive days of hearing, excessive transcripts, etc. However, hearings represent only 10% of claims processed. The changes in the administrative structure of this program by the admendments to the L&HWCA in 1972 should provide an excellent opportunity for the introduction of positive caseload management techniques.

VI. Public Assistance Programs

Public assistance programs are administered by the states. The basic pattern for claims determination has two levels, an initial determination by eligibility technicians in local welfare offices followed by a hearing at the request of the claimant before a hearing officer who has not been involved in the initial decision. In some states there is a further administrative appeal, usually on the record at the hearing, and/or judicial review. Issues of state compliance with the federal Constitution or the Social Security Act and its attendant regulations may sometimes be litigated in the federal courts.

The Quality Control System employed by the Assistance Payments Administration (APA) in HEW for Aid to Families with Dependent Children (AFDC) and the Title XVI programs (OA, AB and APTD), which will be transferred to the Social Security Administration by January 1, 1974, has several features which distinguish it from SQA systems in the larger feder-

ally administered programs like Veterans' Pensions and Compensation or Social Security. The basic difference is that the principal interest in quality control in public assistance is not the assurance of accuracy, fairness and timeliness in all adjudications, but rather the protection of the federal treasury from incorrect state-authorized payments. This interest affects the methodology and focus of quality control reviews and the aspects of the adjudication process covered.

The QC system in public assistance is actually a state run program which is designed and mandated by HEW as a condition on the receipt of federal grant-in-aid funds. Quality control is defined as

> [A]n administrative program for determining the extent to which those receiving public assistance are (1) eligible for assistance, and (2) receiving assistance payments in the amount to which they are properly entitled. It is used by the state and federal governments to maintain a continuing and systematic control over the incidence of ineligible recipients and incorrect payments in public assistance caseloads.
>
> As a method of state administration, the quality control system has the purpose of holding the incidence of error below pre-established tolerance limits of errors. It accomplishes this purpose by means of three processes: (1) continuous review of statistically reliable statewide samples of cases; (2) quarterly assembly and analysis of case findings to determine incidence of errors; and (3) when tolerance limits are found to be exceeded, corrective action to bring the level of erroneous cases within the tolerance established.

Actually this manual definition is somewhat out of date. Reports are now compiled every six months, but data on overpayments and improper positive actions must be reported monthly.

Sample sizes for each state are specified by HEW and the state quality reviewers redetermine each case that shows up in the sample. Review is not on the record of the decision as initially made, save in the case of denials or terminations, because the question that is being asked in this system is whether the recipient is currently entitled to be on the rolls and is receiving a correct payment. Hence a determination of eligibility based on the absence of the father will not be noted as an error if the father is present but disabled and therefore the family is eligible. Moreover, there is no review for timeliness (although there are statutory and regulatory rquirements of promptness) nor is there a quality review of adjudications in administrative appeals ("fair hearings").

Nevertheless, the review procedures and notations concerning initial and periodic redeterminations do reveal a substantial amount of information about the incidence and reasons for errors in initial adjudications. The reviewer is instructed to check all elements of eligibility and to determine whether an error has been made, about what, and why an error occurred (three major categories: incorrect application of policy, computation or other technical error, or failure to take indicated action to develop facts). Interestingly, errors may also be assigned to the claimant under this system because many determinations are made on the basis of claimant declarations and the recipient has a continuing obligation to report changes of status which affect payments or eligibility.

The tolerance levels for error in public assistance determinations have been set at 3% for positive and negative eligibility errors and 5% for overpayments and for underpayments. In fact states constantly exceed these error rates, even though the $\pm 3\%$ sample variation allows a cumulative 28% error rate

if nicely distributed. That no or ineffective corrective action is taken to deal with these errors is common knowledge. Recent regulations permit HEW to disallow federal matching to the extent that the states' overpayments and payments to ineligibles exceed the tolerance levels specified. The states have complained that the tolerances are too low given the complexity of the determinations and their necessary reliance on client declarations and reporting of changes. And, indeed some quality control reports reveal an incidence of client error which is above the tolerance without taking into account agency errors. HEW has responded to these complaints by proposing regulations which would permit states to check client-supplied information more carefully, to eliminate the self-declaration method of application currently required in some programs, to spend longer times validating claims and to use local rather than state hearing officers in pre-termination hearings.