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Administrative Conference of the United States
Suite 706 South
1120 20th Street NW
Washington, DC 20036
Via e-mail: info@acus.gov

RE: Identifying and Reducing Burdens in Administrative Processes

Dear Administrative Conference of the United States,

The Homeless Action Center (HAC) is a nonprofit law office that provides Social Security Representation at no cost to mentally ill, unhoused residents of Alameda County, California, since 1990. We currently represent over one thousand clients. While representing individuals with Social Security and SSI disability-based claims, HAC also represents individuals in obtaining and retaining Supplemental Nutrition Assistance Program (SNAP), Medicaid, Temporary Assistance for Needy Families (TANF), and local welfare benefits. HAC appreciates the Administrative Conference of the United States (ACUS) requesting comments on ways agencies can identify and reduce unnecessary procedural burdens that members of the public face when they engage with administrative programs or participate in administrative processes.

Access Issues

A. Phone

It is very difficult to reach the local Social Security offices (Field Offices) by phone, as customers regularly experience dropped calls and extremely long wait times. While this is a longstanding customer access issue, during the pandemic the phone issues increased precipitously. In 2022, the phone systems stopped working while the field offices were still closed to in-person service; as such, access was denied entirely. HAC's phone systems allow us to monitor our outgoing call success rate by phone number called. We tracked a month-long period where 62% of calls to Alameda County Field Offices did not connect. Things have improved since the height of the pandemic, but substandard phone systems are still a burden. Calls are still not connected or are dropped regularly, and when calls do go through, very long wait times are the norm.

When HAC staff do reach Field Office staff by phone, they are often recalcitrant. When we dial an extension for a specific claim staff, they almost never answer the call and when we leave a message for the relevant claims staff it is very unusual to receive a call back. HAC meets regularly with local Field Offices, and these meetings center around the same issues again and again, including phone messages not being returned, mail being lost, faxes being lost,

information not being processed timely, or information not sent timely to the Disability Determination Services that evaluates disability at the initial and reconsideration levels or to the Office of Hearings Operations. We have informal, individualized systems set up with every local Field Office for what to do when we do not hear back from Field Office staff after multiple attempts. These systems are in place because non-responses and lack of action are routine. Generally, calling or e-mailing supervisors is the next step, but this often leads to no response, requiring yet another step of reaching out to the regional communications director.

As a non-profit that works with Social Security routinely and is very familiar with navigating bureaucracy, HAC still has these issues connecting with the Administration and receiving competent assistance. These burdens are much harder to overcome for our clients and unrepresented claimants and beneficiaries. When phone systems do not work and calls do not go through, claimants may assume it is an error on their end, and not continue trying to call. When Social Security staff are rude or dismissive to them, they may not feel comfortable pushing back. When Social Security staff give out incorrect or incomplete information, claimants may not know this. As Social Security assists individuals with disabilities and the elderly, many of whom cannot make it into the office and do not have internet access or internet fluency, it is essential that their phone systems are accessible and customer friendly. The Social Security phone systems need an upgrade, and their processes around answering phones and returning calls need an overhaul. Social Security Field Offices treat phone calls and phone messages as peripheral tasks outside of their real work. Work processes should be modified to include taking and returning phone calls as part of the workload, with sufficient time and space allotted for workers to do this. There needs to be more staff, especially more knowledgeable staff, available to answer phones.

HAC also works with our local Social Services Agency that administers federal and state-federal benefits including SNAP, TANF, and Medicaid. Their phone system is not capable of handling the call volume they receive. Callers often receive a message that there are too many calls and to call back later before the call disconnects, with no opportunity to wait on hold or leave a message. We raise this with the Social Services office regularly at bimonthly meetings. They are aware of the issue and say it is due to staffing difficulties, they recommend people call at 8:30 in the morning when call volume is the lowest. Phone access must be improved, as people with disabilities cannot always make it into the offices or call at that specific time.

In addition, Alameda County Social Services Agency switched several years ago from each beneficiary having a worker to cases being handled by a collective phone bank of workers. This means there is no direct line beneficiaries can call, or extension they can dial. Instead, they must call the main phone number to reach someone to discuss their cases with, but most of the time that line hangs up on customers without even giving the option to wait on a very long hold. There are many things that cannot be done online with these programs, so phone or in-person are often the only options. However, in-person visits lead to long waits and are not feasible for many, due to transportation difficulties and/or physical and mental disabilities. Lack of phone access results in eligible people improperly being cut off benefits or having their benefits reduced more often. Lack of phone access also results in represented people appealing cases more often. Issues that could be settled through a simple phone call must be escalated to a fair hearing, costing the administration much more and resulting in clients spending long periods

without benefits for which they are eligible. Thus, better phone systems and more staffing are needed to improve access to program beneficiaries.

B. Mail and Fax

Mail sent to Social Security Field Offices is routinely lost. This is a large problem as certain essential documents, including the SSI application, require a wet signature. Thus mailing or going in person to the office is the only option. Once these documents are lost, a copy does not suffice, as it no longer contains a wet signature. More troubling is that Social Security often directs people to send important documents into the Field Office, including green cards to verify immigration status. Creating a better mail receiving system is necessary. Faxes sent to Social Security are routinely not timely processed or not processed at all. This creates delays in cases being processed, moved to other offices, and overpayments being remedied. When faxes are not processed timely, individuals end up having to call multiple times to ask Field Office staff to process the fax, taking up more staff time and resources.

Mail sent to Social Services is also routinely lost. Documents uploaded or faxed are often sent into a client's file, but no worker acts on them. Systems are set up for SNAP, Medicaid, and TANF such that if a worker does not note the receipt of the documents, it is assumed necessary paperwork- such as annual redeterminations- were not received, and the benefits are stopped. It is a common occurrence for individuals' benefits to be stopped despite being eligible and having returned all required paperwork, timely. To remedy this in the best case scenario, the denial is appealed costing the administration time and money. In the worst case scenario, an eligible individual no longer has benefits they need to eat, receive medical care, or pay their rent. A better system would be to keep the beneficiary on the benefits until the worker specifically inputs that the paperwork was not received timely. This would put the impact of workers failing to enter things timely on the County, rather than the claimant. There may still be administrative burdens, but the beneficiaries' benefits would not be negatively impacted.

C. Internet

During the pandemic it became clear that Social Security's internet services are insufficient to cover all Social Security client needs. Many of our clients lack internet access, access to a computer, and/or have very limited access through free government flip phones. Those that do have internet access are rarely able to accomplish what they need to on the website. Social Security created my Social Security (MySSA) accounts as an online account where people can theoretically accomplish many things online. Unfortunately, MySSA accounts are an attempted burden-reduction effort that ended up creating more burdens for those who cannot create and access a MySSA account. Our clients are rarely able to successfully create MySSA accounts. Creating a MySSA account requires a significant amount of identity verification. SSA uses information from Experian, requiring knowledge of past addresses and other information used for credit checks. These are complicated questions for homeless and transient individuals, the vast majority of whom have had many addresses associated with their names over the years. Individuals with memory impairments are also generally unable to sign up for these accounts. Without a MySSA account, many online services are not available. Access to MySSA should be

made simpler and several things that can be done on MySSA should also be accomplishable on the Social Security website, such as ordering replacement Social Security cards.

While some Social Security Agency applications are available online and can be filled out by an advocate, there is not sufficient online access in these areas. Filing an SSDI application online without a MySSA account adds weeks to the process, as SSA mails documentation to the applicant to sign and send back. The application will not be processed until this signed documentation has been received; once received at SSA it typically takes weeks or months for them to process the application. SSI applications are only available online to a few individuals and are not available to anyone who has an advocate filing the application for them. One of the biggest delays we experience regularly is that SSA loses SSI applications that have been mailed or faxed in. When an SSI application is lost, the need for a wet signature becomes a problem, as the application that contains the wet signature is now gone. Even when the SSI application has not been lost, it still takes multiple follow up calls for field offices to process them. Conversely the online appeals system is easy to access and use, does not require a MySSA account, and works for both SSI and SSDI claims. All SSA online services should be raised to the level of ease and access that the appeals system has achieved.

Interagency Burdens

Social Security contracts with the Disability Determination Services (DDS) to determine disability at the initial and reconsideration level. While representatives can submit a client's medical evidence directly to DDS, they cannot submit the form (SSA-1696) that appoints them as a representative and allows the DDS analysts to communicate with them. Representatives must submit the 1696 to the Social Security Field Office, which then processes the form and uploads it to a place the DDS analyst can view it. This is a burden, as the Field Office often loses the 1696, takes an exceedingly long time to process it, or fails to upload it to the correct place where DDS can access it. This leads to situations where advocates cannot submit information DDS analysts need to complete the case, or analysts do not even know of the representative's existence. The 1696 issue often prompts the analyst to close the case without seeking out information from the representative and without notifying the representative of the denial, causing the claimant to miss the time frame to appeal. To remedy this, DDS analysts should be able to accept 1696s directly from representatives.

Social Security also contracts with Direct Express. SSI and SSDI recipients who cannot utilize a bank account or choose not to, receive their benefits on a Direct Express card. Direct Express has appalling customer service. It is nearly impossible to reach them by phone. Resolving issues with them take herculean efforts. Social Security should contract with an agency that is better set up to work with individuals with disabilities and that can provide excellent customer service and ease of access.

SNAP, Medicaid, and TANF are administered by individual county offices in California. When beneficiaries move counties, they are required to jump through many administrative hoops to maintain their benefits, and their benefits are often cut off or are inaccessible while the counties communicate with each other. Moving counties creates an unnecessary burden where people are

penalized for not living their lives within the confines of one county. For example, an individual receives the same amount of CalFresh regardless of the county they live in, and so it should not be a county dependent benefit. Homeless CalFresh recipients often move around and stay some nights in one county and some in another. They can be subject to investigation or penalized for simply buying needed food in a neighboring county. To accommodate this reality, it would be far more expeditious if it were a state-based program instead of a county one.

Disability Determination Services

DDS can schedule Social Security claimants for consultative examinations (CE) when there is insufficient evidence to determine disability. CEs are performed by medical providers who contract with DDS. CE providers are not familiar with the claimants, meeting them only during the one-time exam. There is no minimum for how long these appointments last. It is not unusual for a CE to last less than 20 minutes but still dictate the entire outcome of a claimant's case. DDS Analysts tend to routinely schedule CEs even when the claimant has a treating provider who can perform an examination themselves or provide an opinion. Changes in how medical evidence is evaluated have made these medical opinions distinct from the information found in regular medical records, but at the same time the medical opinions are the only medical evidence for which analysts and judges need to articulate their findings. *See* 20 CFR § 404.1520c.

Analysts should have to seek an exam and an opinion from treating providers before they look for a CE provider. The rules do recommend this practice, but it is not actually followed by analysts. Unnecessary CEs are a waste of money, produce unpersuasive evidence, and can be traumatizing for claimants. There should be a shift so that opinions from treating providers must be sought and followed up on by analysts before a CE is contemplated or required.

Office of Hearing Operations

The Office of Hearing Operations (OHO) hears Social Security cases. Administrative Law Judges (ALJ) hold hearings where claimants testify, as do vocational experts and sometimes medical experts. Prior to these hearings the ALJs have access to all of the evidence in the files. At these hearings, there is not generally a discussion of which issues the ALJs have concerns or questions about. The hearing decision issued after the hearing is the first time the claimant learns what issues or concerns the ALJ harbors. The only recourse at this point is to appeal the decision to the Appeals Council. It would be a smoother process if ALJ's issued a tentative ruling before the hearing. The tentative ruling would put the claimant and their representative on notice regarding areas of concern, allowing them the opportunity to specifically address those issues at the hearing.

Vocational Experts (VEs) often testify at hearings regarding what jobs, if any, are potentially performable by a hypothetical individual with the same limitations as the claimant may have. In their opinions of the claimants' abilities, CE providers and others fill out forms issued by Social Security that ask whether a claimant has none, mild, moderate, or marked limitations in a particular area of functioning. Social Security has never issued a clear definition of these terms. For example, they define moderate as more than mild but less than marked. VEs when asked

how these limitations would impact a possible job market, are unable to give a reply unless the terms are translated into a numerical definition. This leaves the claimant or attorney to make up what exactly the CE provider meant when the said an individual is moderately impaired in their ability to concentrate or keep on pace. An attorney can say that moderate meant they would be unable to do that 5% of the workday, or 15%, as there is no guidance from Social Security on this. Even if the VE finds that limitations would indicate the hypothetical individual cannot work, the ALJ can later find the definition was unrealistic. Having Social Security forms filled out by Social Security contracted doctors resulting in information that cannot be used to question Social Security contracted VEs without making up additional information is an unnecessary burden. Social Security should define mild, moderate, marked, and extreme in such a way that VEs can use the information to provide meaningful testimony.

Social Security Process

The entire Social Security disability claims process would be much more streamlined if Social Security's default position was to believe claimants and their doctors. In a very large number of cases, the opinions of doctors who have been treating individuals for years are found unpersuasive in favor of the opinion of an agency doctor who has never met the claimant and merely reviewed their paperwork. The culture of assuming claimants are lying, exaggerating, or in some way perpetrating fraud, ends up costing the agency much more in the end, than the cost of not assuming the claimants and evidence from their doctors is false. There is a large number of cases remanded back to Social Security from the federal courts, showing that the denials are being made in error.

Other benefit programs do not have this same adversarial-like system. For example, California State Disability Insurance generally grants the claim based on paperwork filled out by the applicants' doctor(s). Disbelieving doctors and claimants creates a huge bureaucracy of denials and appeals costing the administration millions and preventing eligible individuals from accessing needed benefits.

In addition, many cases are denied multiple times before they are eventually approved on the exact same evidence once someone more knowledgeable and experienced takes the time to look at the case and correctly apply the laws. The initial and reconsideration stages have extremely high denial rates, and no lawyers or judges are ensuring the rules are correctly applied at these levels. Many unrepresented claimants do not know that the hearing approval rate is much higher than the initial, and that they can and should appeal, instead reapplying. This deprives the claimants of months of potential back pay, in addition to adding to administrative burden. The reconsideration stage has the highest denial rate with analysts mostly rubberstamping the decision made by the initial analyst. Eliminating the reconsideration stage would save money for Social Security and allow claimants to have their day in court sooner.

Sincerely,
/s/
Patricia E. Wall
Executive Director