Office of the Inspector General
SOCIAL SECURITY ADMINISTRATION

Audit Report

The Social Security Administration's Expansion of Health Information Technology to Obtain and Analyze Medical Records for Disability Claims

A-01-18-50342 | January 2022

Office of the Inspector General
SOCIAL SECURITY ADMINISTRATION

MEMORANDUM

Date: January 3, 2022 **Refer To:** A-01-18-50342

To: Kilolo Kijakazi
Acting Commissioner

From: Gail S. Ennis, Gail S. Ennis
Inspector General

Subject: The Social Security Administration's Expansion of Health Information Technology to Obtain and Analyze Medical Records for Disability Claims

The attached final report presents the results of the Office of Audit's review. The objective was to assess the Social Security Administration's efforts to expand the use of health information technology to obtain and analyze medical records for disability claims.

If you wish to discuss the final report, please contact Michelle L. Anderson, Assistant Inspector General for Audit.

cc: Trae Sommer

Attachment

The Social Security Administration's Expansion of Health Information Technology to Obtain and Analyze Medical Records for Disability Claims
A-01-18-50342

January 2022 **Office of Audit Report Summary**

Objective

To assess the Social Security Administration's (SSA) efforts to expand the use of health information technology (health IT) to obtain and analyze medical records for disability claims.

Background

To make disability determinations, SSA (a) manually requests medical records and receives them in paper format (mail or fax) or through Electronic Records Express (ERE), which is SSA's secure web portal, or (b) requests and receives them *automatically* from health IT.

Health IT is a broad concept that uses an array of technologies, such as electronic health records and exchange networks, to record, store, protect, retrieve, send, and receive medical records securely over the Internet.

It can take SSA days, week, or months to obtain paper records. SSA does not track the time from when it requests and receives ERE records; whereas health IT records arrive in seconds or minutes.

SSA uses its Medical Evidence Gathering and Analysis through Health Information Technology (MEGAHIT) software to automatically request and receive health IT records and perform data analysis.

Conclusion

Despite spending more than 10 years trying to increase the number of medical records received through health IT, SSA still receives most records in paper or ERE format. In the Fiscal Year (FY) that ended on September 30, 2020, SSA received only 11 percent of medical records through health IT.

SSA experienced a decreasing trend in adding new health IT partners from 56 in FY 2018 to 12 in FY 2021 (as of August). During this time, SSA reduced the number of staff and contractors involved in health IT outreach and did not fully fund projects to increase electronic medical evidence. Also, expanding the number of health IT records by adding new partners is not a unilateral decision made by SSA, as prospective partners must be willing and able to meet SSA's technical requirements, and COVID-19 was a factor. In October 2021, SSA informed us it was (a) working on *Memorandums of Understanding* with 3 entities to exchange health IT records with over 30 large health IT organizations and (b) adding more staff to develop and implement strategies to expand health IT.

Challenges in expanding the number of health IT records include some partners' inability to send sensitive medical records, acceptance of SSA's authorization form to release records to the Agency (Form SSA-827), and medical industry-wide differences in patient-identifying data fields.

Additionally, SSA has had limited success analyzing medical records because MEGAHIT is limited to analyzing only structured data. MEGAHIT generated data extracts on only 7.3 percent of the 1.6 million health IT records SSA received in FY 2020. The extracts assist SSA disability examiners in making accurate disability determinations. Since 2018, SSA has been developing and testing the Intelligent Medical-Language Analysis GENeration application with new capabilities for reviewing medical records. As of August 2021, SSA was still testing and rolling out this application to its offices.

Recommendation

We recommend SSA intensify efforts to increase the number of health IT partners. SSA agreed with the recommendation.

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ABBREVIATIONS

C.F.R.	Code of Federal Regulations
DDS	Disability Determination Services
ERE	Electronic Records Express
Form SSA-827	*Authorization to Disclose Information to the Social Security Administration*
FY	Fiscal Year
GAO	Government Accountability Office
Health IT	Health Information Technology
HHS-ONC	The Department of Health and Human Services, Office of the National Coordinator for Health Information Technology
IMAGEN	Intelligent Medical-language Analysis GENeration
MEGAHIT	Medical Evidence Gathering and Analysis through Health Information Technology
OIG	Office of the Inspector General
POMS	Program Operations Manual System
Pub. L. No.	Public Law Number
SSA	Social Security Administration
Stat.	Statutes at Large
U.S.C.	United States Code

OBJECTIVE

Our objective was to assess the Social Security Administration's (SSA) efforts to expand the use of health information technology (health IT)[1] to obtain and analyze medical records for disability claims.

BACKGROUND

SSA provides Disability Insurance benefits and Supplemental Security Income disability payments to eligible individuals.[2] The SSA field office generally forwards the claim to the disability determination services (DDS) in the State or other office with jurisdiction to determine whether an applicant is disabled under SSA's criteria.[3] Disability applicants must inform SSA about or submit all evidence known to him/her that relates to whether he/she is blind or disabled.[4] An applicant or his/her representative can submit records directly to SSA. An applicant can also sign a Form SSA-827, *Authorization to Disclose Information to the Social Security Administration,*[5] to allow SSA to obtain copies of medical records from health care providers that have evaluated, examined, or treated him/her. SSA's policy states, "Before we make a determination that the claimant is not disabled, we will . . . [m]ake every reasonable effort to develop the claimant's complete medical history."[6]

There are approximately 624,000 physicians and 6,000 hospitals in the United States.[7] In the Fiscal Year (FY) ended September 30, 2019, health care organizations provided approximately 80.7 percent of the records SSA used to make disability determinations (see Table 1).

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[1] SSA uses health IT to automatically request and receive disability applicants' medical information electronically.

[2] 42 U.S.C. §§ 423 and 1381a.

[3] 42 U.S.C. §§ 421 and 1383b(a); 20 C.F.R. §§ 404.1601 and 416.1001.

[4] 20 C.F.R. § 404.1512(a)(1) and 416.912(a)(1).

[5] Form SSA-827 serves as a claimant's written request to release information. SSA, *POMS*, DI 11005.055, (October 9, 2014).

[6] SSA, *POMS*, DI 22505.001, B.2 (September 17, 2020). SSA will request medical records and follow-up between 10 and 20 calendar days if it does not receive them. 20 C.F.R. § 404.1512(b)(1) and 416.912(b)(1). See also 42 U.S.C. §§ 423(d)(5)(B) and 1382c(a)(3)(H)(i).

[7] Department of Health and Human Services, *The Number of Practicing Primary Care Physicians in the United States*, Agency for Healthcare Research and Quality, ahrq.gov (July 2018) and American Hospital Association, *Fast Facts on U.S. Hospitals, 2021 Edition,* aha.org (January 2021).

Table 1: Sources of SSA Medical Records - FYs 2017 Through 2019

Source of Medical Records	FY 2017 Number and Percent of Medical Records		FY 2018 Number and Percent of Medical Records		FY 2019 Number and Percent of Medical Records	
Health Care Organization, such as Hospitals and Physicians	16,832,126	77.5%	16,496,321	78.3%	14,084,934	80.7%
Claimant Representative[8]	2,299,553	10.6%	2,156,029	10.2%	1,403,692	8.1%
Consultative Examination[9]	2,271,736	10.4%	2,092,081	10.0%	1,757,895	10.1%
Claimant	277,467	1.3%	276,571	1.3%	163,070	0.9%
Educational Facilities[10]	50,881	0.2%	49,066	0.2%	42,421	0.2%
TOTAL	**21,731,763**	**100%**	**21,070,068**	**100%**	**17,452,012**	**100%**

The Social Security Administration's Process for Obtaining Medical Records

SSA pays approximately $500 million per year to obtain medical records by paper, Electronic Records Express (ERE), and health IT.[11]

- Paper consists of medical records SSA obtains through regular mail or fax (or if dropped off at an SSA office by a claimant or claimant representative.)[12] Paper records can take days, weeks, or months for SSA to receive because manual processes are involved; most of the time is spent waiting for records to arrive. This time involves:
  - SSA calling, mailing, and/or faxing requests for records with a Form SSA-827;[13]
  - health care providers receiving requests, pulling records, and sending records to SSA;
  - SSA scanning responses that are stored as unstructured data;[14] and

[8] Individuals filing an application for Old-Age, Survivors and Disability Insurance benefits or Supplemental Security Income payments may appoint qualified individuals as representatives to act on their behalf in matters before SSA. 20 C.F.R. §§ 404.1705 and 416.1505, and SSA, *POMS,* GN 03910.020 (May 1, 2013).

[9] SSA authorizes DDSs to purchase consultative examinations including medical examinations, X-rays, and laboratory tests, when the existing records are insufficient to make a determination. *POMS*, DI 39545.120, A. (June 5, 2017).

[10] Educational facility (such as school) records may contain medical information. SSA, *POMS,* DI 81020.040, B.3 (d) (February 11, 2019).

[11] SSA, *Operations Analysis: Electronic Evidence Acquisition*, p. 3 (April 2020).

[12] If SSA employees receive medical evidence via email, Agency policy requires they inform the sender that email is not secure and advise them to mail or fax copies of the records or use the ERE Website. SSA, *POMS,* DI 81020.060, B. (June 7, 2011).

[13] SSA, *POMS*, DI 22505.006, B.2 (March 15, 2017). For telephone requests, SSA will mail or fax the Form SSA-827. SSA, *POMS*, 22505.030, B.1 (b)(1) (April 2, 2021).

[14] Unstructured data cannot be easily organized using pre-defined structures. Examples specific to healthcare include radiology images or text files, like a physician's notes in the electronic health record. *Healthcare Structured vs. Unstructured Data*, https://partners.healthgrades.com/blog/deep-data-dive-structured-and-unstructured-data-in-healthcare-marketing (May 10, 2021).

- SSA paying for records by individual check (see Appendix A for State payment rates for medical records obtained via paper or ERE.)

- ERE allows organizations to upload records directly into claimants' unique SSA electronic folders[15] via SSA's secure Website using a barcode SSA provides.[16] According to SSA, it receives ERE medical records faster than paper records because of the electronic exchange process for *receiving* the records. However, SSA does not track the time from when it requests and receives ERE records.
- Health IT uses an array of technologies—such as electronic health records and health information exchange networks[17]—to record, store, protect, retrieve, send, and receive medical records securely over the Internet. SSA requests and receives health IT records in seconds or minutes because of the automated process, which involves an SSA system:
  - identifying health IT partner(s);
  - sending an electronic request and Form SSA-827 via a health data exchange network;
  - receiving health IT records as both structured[18] and unstructured data from health IT partners; and
  - electronically paying the federally approved rate of $15 per successful transaction.

In August 2008, SSA partnered with a medical provider to pilot a prototype application called Medical Evidence Gathering and Analysis through Health Information Technology (MEGAHIT) and developed standards for the patient-authorized release of health IT records.[19] SSA uses MEGAHIT to automatically request, receive, and analyze health IT records from partner organizations. SSA's health IT partners consist of healthcare organizations, health information exchanges, and other Federal agencies. MEGAHIT's data analytics function uses a set of business rules based on SSA's Listing of Impairments.[20] MEGAHIT business rules include rules for cancers, blindness, amputations, transplants, etc. This functionality analyzes the medical information by looking at diagnosis codes, treatment codes, and other factors and alerts the examiner to significant information. For example, MEGAHIT creates an alert, such as

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[15] SSA's electronic folder contains a claimants' disability information. SSA, *POMS*, DI 81001.005, B (September 11, 2020).

[16] SSA, *Use Electronic Records Express to Send Records Related to Disability Claims*, Publication 05-10046 (September 2020). Some providers use vendors to release records to SSA via secure file transfers or web services.

[17] A health information exchange network allows health care organizations to appropriately access and securely share patients' medical information electronically.

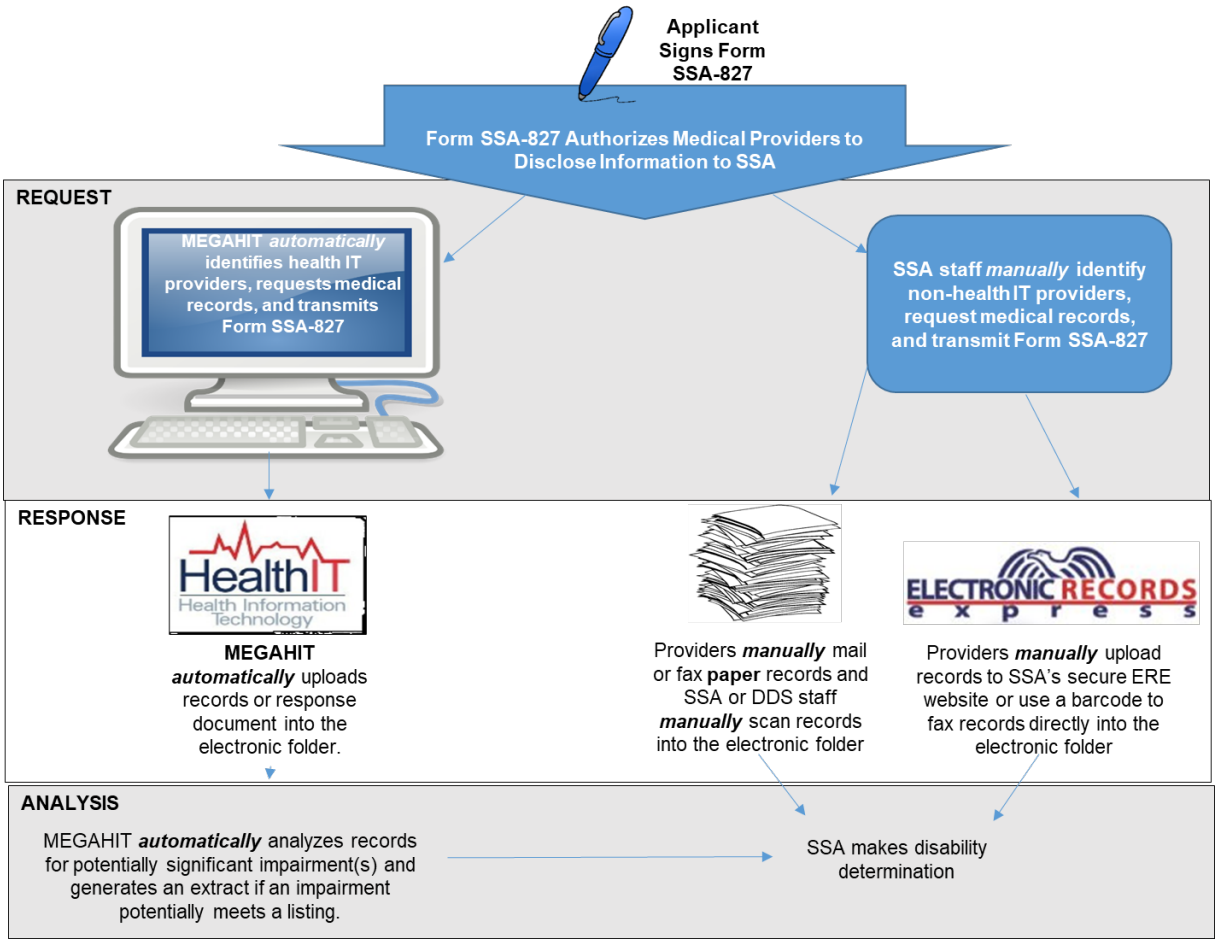
[18] Structured data can be found in any healthcare database and may include details like customer names and contact information, lab values, patient demographic data and financial information. *Healthcare Structured vs. Unstructured Data*, https://partners.healthgrades.com/blog/deep-data-dive-structured-and-unstructured-data-in-healthcare-marketing (May 10, 2021).

[19] SSA, OIG, *Health Information Technology Provided by Beth Israel Deaconess Medical Center and MedVirginia, A-01-11-11117* (October 2011).

[20] SSA's Listing of Impairments describes, for each of the major body systems, impairments that the Agency considers to be severe enough to prevent an individual from performing gainful activity, regardless of his or her age, education, or work experience. 20 CFR §§ 404.1525(a) and 416.925(a). An impairment medically equals a Listing if it is at least equal in severity and duration to the criteria of any listed impairment. 20 C.F.R. §§ 404.1526(a) and 416.926(a). If a condition meets or medically equals a Listing, and the claimant is not performing substantial gainful activity, SSA will find the claimant disabled. 20 C.F.R. §§ 404.1520(b) and (d) and 416.920(b) and(d). SSA, *POMS*, DI 24508.010 (February 13, 2018); DI 24508.005 (April 2, 2018); and DI 34000.000 (July 22, 2021).

". . . preliminary computer analysis indicates that 'specific listing' should be considered in this case." As additional health IT documents are added to the claimant's electronic folder, the rules are rerun across both the new and existing health IT documents looking for matches. See Figure 1 for a flowchart of SSA's processes to obtain and analyze medical records.

Figure 1: SSA's Processes to Obtain and Analyze Medical Records



Benefits of Health Information Technology

As shown in Table 2, SSA makes disability determinations quicker with health IT records; and a faster allowance determination by SSA means disabled beneficiaries have quicker access to cash benefits and health care coverage. In a prior review, we concluded the wait for benefits affected at least one aspect of a disability claimant's life, such as their finances, access to medical care, and relationships.[21]

[21] SSA, OIG, *Congressional Response Report: Impact of the Social Security Administration's Claims Process on Disability Beneficiaries*, *A-01-09-29084* (September 2009).

Table 2: Comparison of Initial Case Processing Times with and Without Health IT Records for FYs 2017 Through 2020

FY	Average Processing Time for Cases Without Health IT Records (Days)	Average Processing Time for Cases with at Least One Health IT Record (Days)	Average Processing Time for Cases with Only Health IT Records (Days)
2017	89	79	59
2018	91	82	61
2019	95	88	64
2020	107	101	70

Prior Report on Health Information Technology

In a 2015 audit, we found that despite challenges, SSA continued to expand the number of health IT partners and had 38 health care partners in 30 States and the District of Columbia. In addition, the DDS reported they were generally satisfied with MEGAHIT; however, some suggested SSA improve formatting for health IT records to emphasize dates of treatment and omit retracted or repetitive information. We found that MEGAHIT received health IT records 19 days faster than paper and ERE medical records.[22] We made four recommendations that SSA agreed with and implemented; see Appendix B.

Scope and Methodology

We reviewed SSA's processes to obtain medical records; efforts to expand health IT; and use of data analytics to evaluate medical records. We identified a population of 1.7 million individuals who had a health IT request in SSA's electronic folder with a case establishment date in Calendar Years 2016 through 2018. From this population, we analyzed a random sample of 275 cases. We also interviewed managers and staff at the U.S. Department of Health and Human Services' Office of the National Coordinator for Health Information Technology (HHS-ONC) about the nation-wide expansion of electronic health records. See Appendix C for our scope and methodology.

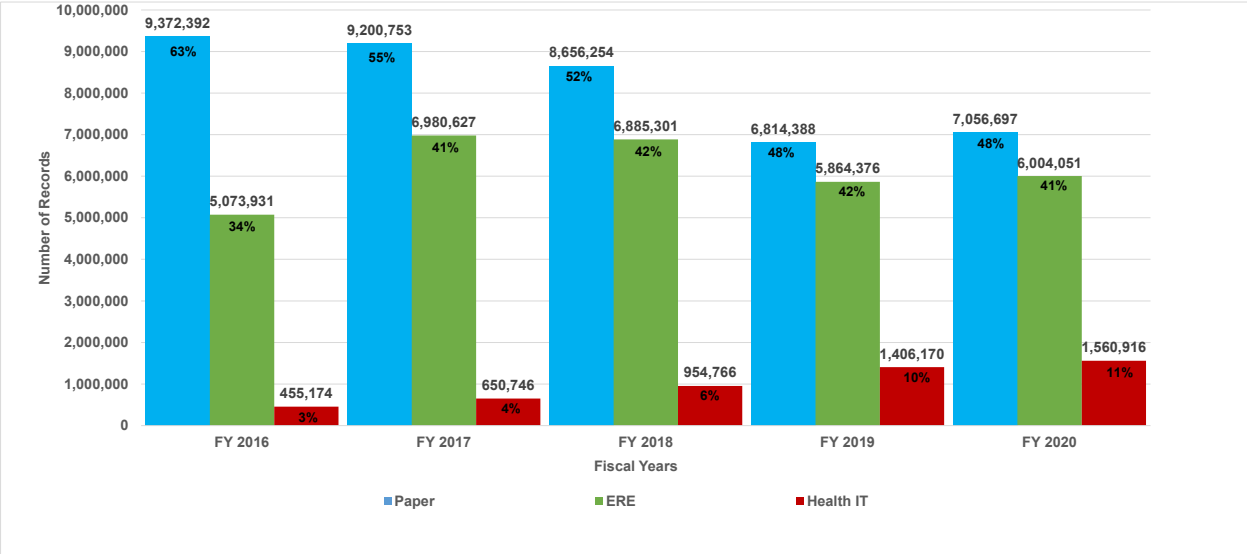
RESULTS OF REVIEW

Although SSA has generally met its targets for increasing the use of health IT to obtain medical records, the Agency still receives most of the medical records it needs to make disability determinations in paper or ERE format—not as health IT, see Figure 2. (See Appendix D for a timeline of SSA's efforts to electronically obtain and analyze medical records.) Since FY 2018, SSA has experienced a decreasing trend in adding new health IT partners. SSA reduced the number of staff and contractors involved in adding new health IT partners, and the Agency did not fully fund projects to increase electronic medical evidence. In addition, prospective partners must be willing and able to meet SSA's technical requirements, including an ability to send sensitive medical records, acceptance of SSA's authorization form to release records to the

[22] SSA, OIG, *The Social Security Administration's Expansion of Health Information Technology, A-01-13-13027, p 10* (May 2015).

Agency (Form SSA-827), as well as medical industry-wide differences in patient-identifying data fields. In October 2021, SSA informed us it was increasing its efforts by working on *Memorandums of Understanding* with three entities to exchange health IT records with over 30 large health IT organizations.

Figure 2: Number and Type of Medical Records - FYs 2016 Through 2020



Additionally, SSA has had limited success in expanding its data analytics of medical records to assist adjudicators in determining whether claimants are disabled. As of FY 2021, SSA was exploring options to *automatically* analyze all medical record formats (paper, ERE, and health IT).

The Agency's Evolving Strategy for Obtaining and Analyzing Medical Records

The Agency's 2014 *Open Government Plan* included a major health IT initiative to reduce the time to obtain medical records needed to support disability determinations and manage the information more efficiently. Per SSA's plan, using health IT provides:

- a fully automated request and receipt process for medical evidence;
- more complete and standards-based medical records; and
- faster disability decisions using extensive rules-based decision support.

SSA's plan was to continue its outreach efforts in FYs 2014 through 2016 to include additional medical providers and collaborate on setting government-wide health IT policy, and by

participating in advisory panels, workgroups, and task forces to ensure SSA's unique business needs were included in national standards and policies.[23]

In FY 2010, SSA set a baseline target: to increase the percentage of disability cases evaluated using health IT.[24] In FY 2014, SSA modified the target: to increase the percent of initial disability claims processed with health IT medical records. The percent of initial claims with health IT grew from 3 to 14 percent, see Table 3.

Table 3: Increase the Percent of Initial Claims Processed with Health IT Medical Evidence FYs 2014 Through FY 2017[25]

FY	Target for Initial Claims with Health IT	Percent of Initial Claims with Health IT	Target Met
2014	2.5%	3.0%	Yes
2015	6.0%	6.1%	Yes
2016	8.0%	9.6%	Yes
2017	12.0%	14.0%	Yes

In FY 2018, SSA modified its performance target again, by combining health IT with ERE medical records because it determined the health IT performance measure did not accurately represent its performance in reference to the rate of electronic evidence received. However, health IT is a fully automated process from the request and receipt of the medical records; whereas ERE involves the manual request of the records and receipt is through fax or requires a manual upload to SSA's system using a bar code.

SSA met its new target for combined health IT and ERE medical records in FYs 2018[26] and 2019 but not in 2020 (see Table 4).

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[23] SSA, *Open Government Plan 3.0 Plan Milestones and Completion Report* (June 2014) and SSA, *Annual Performance Report Fiscal Years 2017 - 2019* (February 2018).

[24] SSA, *Annual Performance Plan for Fiscal Year 2015, Revised Performance Plan for Fiscal Year 2014 and Annual Performance Report for Fiscal Year 2013*, p. 29 (March 2014).

[25] SSA's *Annual Performance Report Fiscal Years 2017 – 2019,* p. 44 (February 2018).

[26] In June 2018, SSA looked into the feasibility of outsourcing the collection of medical evidence to capable industry vendors on a nation-wide basis. SSA received 16 responses and established a panel to determine which vendors could meet its needs. However, after this review, SSA leadership preferred to consider other alternatives based on emerging technologies and advances in patient health and took no procurement action related to this effort. SSA could not provide us with a cost analysis to support this decision. SSA, *Request for Information for SSA's National Medical Evidence Collection, SSA-RFI-18-622* (June 22, 2018).

Table 4: Improve the Disability Process by Increasing the Percentage of Medical Evidence Received from Health IT and ERE FYs 2018 Through 2020[27]

FY	Target for Initial Claims with Health IT or ERE	Percent of Initial Claims with Health IT	Percent of Initial Claims with ERE	Percent of Initial Claims with Health IT and ERE	Target Met
2018	45.0%	6.0%	42.0%	48.0%	Yes
2019	50.0%	10.0%	42.0%	52.0%	Yes
2020	60.0%	11.0%	41.0%	52.0%	No

The actual percent of initial claims with health IT records in FYs 2018 through 2020 (Column 3, Table 4 – 6, 10, and 11 percent) was less than the FY 2017 level (Column 3, Table 3 – 14 percent). Therefore, SSA's updated strategy did not help it increase the number of health IT records it received. According to SSA, several factors impacted its ability to meet its FY 2020 target, such as an increase in faxed (non-electronic medical evidence) submissions by 7.26 percent after 3 consecutive years of decreases and setbacks due to the COVID-19 pandemic (that is., Health IT partners redirecting resources).

In its *Annual Performance Report for Fiscal Years 2019-2021*, SSA's key initiative was to *Expand Access to Electronic Medical Evidence* and it no longer included a specific target for just health IT records.

> We depend on healthcare providers to provide medical records we need to determine whether a claimant is disabled. Expanding the use of electronic medical evidence allows disability adjudicators to easily navigate the record to identify pertinent information, makes it easier for medical providers to submit evidence, and provides our agency with additional opportunities to use data analytics to improve the disability process.[28]

Challenges the Agency Faces in Obtaining and Analyzing Health Information Technology Medical Records

The HHS-ONC reported that, in FY 2017, 80 percent of office-based physicians and 96 percent of non-Federal acute care hospitals used certified electronic health records.[29] Although medical providers have electronic health records, they may not be able to send those records to SSA.

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[27] SSA, *Annual Performance Report Fiscal Year 2020*, p. 20 (January 2021) and *Annual Performance Report, Fiscal Years 2019-2021*, p. 18 (February 2020). SSA's health IT goal for FY 2020 was established before the COVID-19 pandemic.

[28] SSA *Annual Performance Report, Fiscal Years 2019-2021*, p. 18 (February 2020). SSA's target for electronic medical evidence includes both ERE and health IT.

[29] Health IT Dashboard, *United States Health IT Summary*, healthit.gov (December 7, 2020). The HHS-ONC Certification Program assures that a system meets the technological capability, functionality, and security requirements adopted by the Department of Health and Human Services. The HHS-ONC tracks the adoption of electronic health records for non-Federal acute care hospitals and office-based physicians in the United States, which ". . . . comprise a majority of those providers eligible for the Centers for Medicare & Medicaid Services' Promoting Interoperability Program, and are the primary source of health care for many Americans."

The HHS-ONC reported that, in both 2015 and 2017, ". . . about only 1 in 10 physicians engaged in all 4 domains of interoperability," which is the ability to send, receive, find, and integrate health information received from outside sources and use that information to inform clinical decision-making.[30] Additionally, the ". . . most frequent reported barrier to electronic exchange was difficulty exchanging data across different [electronic health records] vendor platforms."[31]

In February 2009, the President signed the *American Recovery and Reinvestment Act of 2009* into law.[32] The Act provided $40 million to SSA for health IT research and activities to facilitate the adoption of electronic medical records, including the transfer of funds to the Supplemental Security Income Program to carry out activities under the *Social Security Act*. SSA used over $17 million of these funds to form health IT partnerships. However, according to the HHS-ONC,[33] since the *American Recovery and Reinvestment Act* funds have been completely distributed, there are no financial incentives for organizations to offset the cost of implementing an electronic records process.[34]

As of August 2021, SSA had added 12 new partners for a total of 209 health IT partners, that comprised more than 26,000 health care providers in 49 States.[35] However, since FY 2018, SSA has experienced a downward trend in adding new partners (see Figure 3). SSA informed us that "There is no way for us to know for certain for FY 2019 [why fewer partners were added]. Adding partners is not a unilateral decision as prospective partners must be willing and able to partner with us, and each has their own reasons for pursuing or not pursuing this relationship . . . For FYs 2020 and 2021, we know that the COVID-19 pandemic was the main factor. Prospective partners reacted to the pandemic and changed their priorities, as with the rest of the health care industry."

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[30] Vaishali Patel, MPH PhD; Yuriy Pylpchuk, PhD; Sonal Parasrampuria, MPH; and Lolita Kachay, MPH, *Interoperability among Office-Based Physicians in 2015 and 2017,* The Office of the National Coordinator for Health Information Technology, O*NC Data Brief*, No. 47, p. 1 (May 2019).

[31] Yuriy Pylpchuk, PhD; Christian Johnson, MPH; Vashali Patel, PHD MPH, *State of Interoperability among U.S. Non-federal Acute Care Hospitals in 2018*, The Office of the National Coordinator for Health Information Technology, *ONC Data Brief*, No. 51, p. 4 (March 2020).

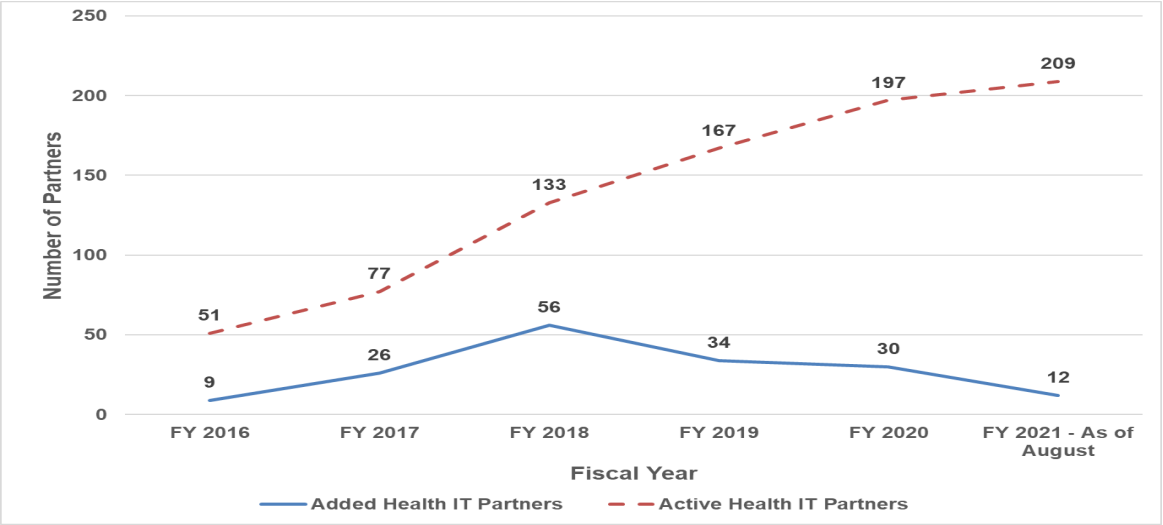
[32] Pub. L. No. 111-5, 123 Stat. 115, 186 (2009).

[33] The HHS-ONC—in the Department of Health and Human Services—is the principal Federal entity charged with coordinating nation-wide efforts to implement and use the most advanced health IT and the electronic exchange of health information.

[34] See Appendix E for a summary of Federal legislation that promotes health IT expansion.

[35] SSA does not have health IT partners in Maine. According to SSA, its Health IT Outreach Team contacted healthcare providers and health information organizations in Maine as far back as 2014. Many of these organizations have not been able to meet its clinical information requirements or were not interested in sharing electronic health information with SSA.

Figure 3: Number of Health IT Partners



SSA identifies potential partners from multiple sources including health IT conferences, SSA regional office staff, DDS referrals, and direct referrals. According to SSA, "Outreach and relationships are essential to our success. Because we do not have financial incentives, such as grants, to help healthcare organizations who wish to connect with us, we must build and maintain relationships with partners, technology vendors, and the DDS."[36] SSA informed us that it could onboard approximately 50 partners in an FY, assuming it can get that many to agree to partner with SSA.

According to SSA, in FY 2021, it had eight staff working on health IT outreach and one subject matter expert focused on developing strategies to expand health IT. However, around 2018, when SSA was bringing more partners on board (as seen in Figure 3), it had more staff working on outreach. Staff used to range from 8 to 10 (4 or 5 full-time employees and 4 or 5 contractors). The most was 12 (8 full-time employees and 4 contractors). In October 2021, SSA informed us that it was re-starting its efforts to expand health IT and its overall strategy is to add two more experts. The experts will advise the Agency on further developing health IT strategies to increase health IT medical records. SSA stated it will continue partnering with organizations that use Epic[37] software and the eHealth Exchange network, but that it was developing new strategies for expanding the health IT records beyond this. SSA prioritizes adding partners who use Epic electronic health record software because Epic provides broad support for the data elements SSA needs to make disability determinations. According to SSA,

[36] SSA, Office of Systems, *Systems F.A.C.T.S. – January 2020, Health IT: HITting a Home Run*, p. 1 (January 2020). DDSs are generally State-run agencies that make disability determinations for SSA using the Agency's regulations, policies, and procedures; 42 U.S.C. §§ 421 ((a)(2) and 1383b (a).

[37] Academic medical centers, community hospitals and other health care providers use Epic electronic health record software to store patients' records.

"Epic is … an early adopter of the eHealth Exchange,[38] which creates a natural synergy as it is the primary network that we use to onboard new organizations."

Challenges with Obtaining Sensitive Records

Some potential health IT partners restrict sharing health records for anyone under age 18, while others cannot provide such sensitive records as substance abuse and mental/behavioral records. According to the HHS-ONC, ". . . because of State or local privacy and security laws, sensitive records may not be sent through Health IT." The HHS-ONC has set the minimum clinical requirement for sharing health information electronically. Many healthcare organizations, along with their associated electronic health record systems, look to the HHS-ONC to establish additional standards and specifications to enable electronic sharing of more types of clinical information electronically. According to the HHS-ONC, the basic requirements to expand data elements should come online over the next few years.

From our 275-case sample, we identified 13 unsuccessful MEGAHIT requests for sensitive records. For instance, on August 24, 2018, MEGAHIT requested a Colorado child's speech therapy records. The partner's system responded with "no patient match." After reviewing SSA's electronic records for this claimant, we could not determine why MEGAHIT's response was unsuccessful. However, the claimant was 3- years-old when the application was filed. On October 2, 2018, SSA mailed a follow-up request and received the medical records via paper (not health IT) on October 5, 2018. Instead of receiving the records via health IT on August 24, 2018 when it initially requested them, it took 42 days for SSA to receive the records.

Challenges with the Agency's Authorization Form to Obtain Health Information Technology Records

SSA has also experienced challenges with health record providers not accepting its Form SSA-827. Some health IT partners:

- only accept Form SSA-827s with a wet signature or eAuthorization;
- will only release records that are dated before the date the claimant signed the Form SSA-827;
- will not release records if the Form SSA-827 signature is older than 60 days;
- require a signature on their own release form in addition to the Form SSA-827; and
- may ask for an updated Form SSA-827 signed by someone applying on the claimant's behalf.

In November 2019, SSA issued a reminder for staff to review Forms SSA-827 to ensure they are correctly completed, legible, signed, and dated before transferring the case to the DDS.[39] MEGAHIT will not generate a request if the Form SSA-827 is not in the electronic folder within

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[38] The eHealth Exchange is the largest healthcare information network in the country and is active in all 50 States. The eHealth Exchange is a network connecting Federal agencies and non-Federal healthcare organizations so medical data can be exchanged nationwide to improve patient care and public health (ehealthexchange.org [May 11, 2021]).

[39] SSA, AM-19031 REV (November 20, 2019).

5 hours of the system first searching for it, is restricted, or is expired. If the Form SSA-827 prevents an automated MEGAHIT transaction, the system will generate a health IT response document alerting staff there is an issue, and the request for health IT will not process.

For our sample, we concluded MEGAHIT was working properly because the system generated an alert notifying staff of invalid information on the Form SSA-827. For example, we identified six cases where MEGAHIT generated a health IT response document alerting staff there was an issue with Form SSA-827. For these six cases, MEGAHIT did not send a request for health IT medical records because it could not identify a Form SSA-827 in the file (two cases), the health IT partner (Department of Veteran's Affairs) only accepts wet signatures (three cases), and the wet-signature was more than 9-months old (one case). For the case where the wet-signature was too old, the evidence showed that an SSA employee initiated a user triggered request for health IT records, but MEGAHIT prevented the request because the Oregon claimant's signature on Form SSA-827 was more than 9 months old. SSA obtained an updated Form SSA-827 and then requested the medical records. To mitigate these Form SSA-827 issues, SSA plans to develop and implement a tool sometime after FY 2021 to automatically validate paper Forms SSA-827 and flag those with invalid inputs.

Challenges Matching Patient-identification Information

Another obstacle limiting the expansion of health IT records is differences in patient-identifying data between SSA and its partners. When SSA requests records, it provides its health IT partners with the claimant's name, date of birth, Social Security number, address, and gender. However, the partner decides how to use the data to identify the claimant in its system. To avoid disclosing the wrong individual's health record, partners typically provide electronic records for only exact data-request matches.

From our sample, we identified 31 MEGAHIT requests that were unsuccessful because of differences between partner and SSA data. For all cases, SSA needed to follow up with a *manual* request to obtain the medical records. For example, on March 24, 2017, MEGAHIT requested a Kentucky claimant's records. The health IT partner responded with a "no patient match" document. On April 24, May 11, and May 26, 2017, SSA followed up by manually triggering MEGAHIT requests and received the same "no patient match" response. On May 26, 2017, SSA faxed a request for records. On June 5, 2017—73 days after the initial MEGAHIT request—SSA received records from the partner. The initial MEGAHIT requests failed because the individual's first name in SSA's system, Jane Lyn, did not match that in the partner's system, Janelyn.

SSA has been an active partner with the HHS-ONC in creating and setting national interoperability standards. In 2018 and 2020, SSA participated in HHS-ONC organized patient matching working sessions to address the industry-wide issue of differences in patient-identifying data. According to the HHS-ONC, it and its Federal partners are working on a *Trusted Exchange Framework and Common Agreement*, which is mandated by the *21st Century Cures Act*.[40] Once finalized, this Framework and Agreement should help enable nationwide exchange of electronic health information across disparate health information networks, and will outline a common set of principles, terms, and conditions. HHS-ONC's goal is to have the *Trusted Exchange Framework and Common Agreement* finalized in 2022.

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[40] *21st Century Cures Act*, Pub. L. No. 114-255, § 4003, 130 Stat. 1033, 1165 (2016).

Challenges in Analyzing Medical Evidence Electronically

A challenge SSA faces in enhancing its data analytics is MEGAHIT's limitation of analyzing only structured health IT data. SSA receives both structured and unstructured data from health IT partners. Per SSA, ". . . the more structured documents (non-image) we receive from partners, the easier it is to execute our business rules…We encourage our partners to provide as much structured dat[a] or as many coded documents as possible."

According to SSA, the number of business rules limits the extracts MEGAHIT can generate. MEGAHIT generated an extract for 7.3 percent of the approximately 1.6 million health IT records in FY 2020. In our sample review, MEGAHIT generated a health IT extract for 14 of 275 cases (5 percent). The extracts assist SSA disability examiners in making disability determinations. While SSA has no technical barriers to adding more business rules, it has not added new rules since 2020 and does not have plans to do so. Instead, in 2018, SSA began testing a new application called Intelligent Medical-language Analysis GENeration (IMAGEN), which would:

- enable adjudicators to visualize, search, and more easily identify relevant clinical content in medical records;
- directly correlate clinical information from medical evidence to SSA's disability impairment listings; and
- improve speed and consistency of medical determinations and decisions.[41]

IMAGEN automates the analysis of medical record content, provides decisional support to disability adjudicators, and will create efficiencies and new knowledge in disability case processing and determinations by using:

- optical character recognition to convert imaged documents into machine-readable text;
- natural language processing to convert text into structured data;
- machine learning and artificial intelligence to mine and model structured data to provide intelligent insights based on historical claim outcomes; and
- a user-interface to provide advanced search, filtering, alerting, annotation, charting, explanation, and medical record summarization features.

Whereas MEGAHIT business rules are limited to analyzing structured health IT medical evidence, SSA is designing IMAGEN to retrieve medical records (both unstructured and structured) in the disability electronic folder and convert them into machine-readable formats. As of August 2021, SSA continued to test and roll out IMAGEN at its offices and at State disability determination services.

[41] SSA, Office of Systems, Systems Talks, Connecting Through Conversations, IMAGEN (June 19, 2019).

The Agency's Plan for Increasing Electronic Medical Records for Fiscal Year 2021 and Beyond

As part of SSA's IT planning for FY 2021 and beyond, in April 2020, SSA's Deputy Commissioner for the Office of Retirement and Disability Policy submitted a proposal to spend $60.1 million over 5 years for electronic evidence acquisition. The proposal included plans to explore and prototype options to automatically exchange all medical record formats—paper, ERE, and health IT—and retrieve medical records from the most appropriate sources in real time to reduce manual intervention, additional requests, and duplicate records.[42] SSA expects this strategy will help it attain its targets of moving away from non-electronic records, decreasing disability determination times, reducing customers' burdens at claim filing, and reducing acquisition costs. While board members of SSA's Information Technology Investment Process voted to approve the proposed investment, ongoing planning discussions resulted in an overall program budget reduction. According to SSA, the project's budget was cut, and therefore, it has been scaled back. Depending on SSA's FY 2022 budget, the project will be restarted or left on pause.

In October 2021, SSA informed us it was jump-starting its efforts to expand health IT. SSA was working on *Memorandums of Understanding* with 3 entities to exchange health IT records with over 30 large health IT organizations. SSA was also planning to:

- analyze geographic variations to identify areas of poor coverage to enable outreach and onboarding of new sources to increase electronic medical records;
- identify large non-electronic providers to try to transition them to providing electronic medical records;
- measure medical source performance (response rates, content quality, etc.) to forecast growth and inform outreach strategy; and
- implement automated notifications based on pre-defined conditions (for example, a decline in medical source response rate, a decline in medical source volume, etc.;) to actively engage partners.

Should additional funding become available, SSA plans to evaluate acquiring structured medical evidence directly from claimants, bypassing the need for lengthy provider onboarding processes.

RECOMMENDATION

We recommend SSA intensify efforts to increase the number of health IT partners.

[42] SSA, *Operation Analysis Electronic Evidence Acquisition*, (April 2020).

AGENCY COMMENTS

SSA agreed with the recommendation, see Appendix F.

Michelle L. Anderson
Assistant Inspector General for Audit

APPENDICES

Appendix A – The Social Security Administration's Medical Record Payment Rates

The Social Security Administration (SSA) will pay a fee for medical records obtained from health care organizations.[1] For health information technology (health IT) records, SSA pays a $15 flat rate for each successful transaction. For medical records obtained via paper (mail or fax) or Electronic Records Express, SSA pays $1 or more based on actual State payment rates.[2] See Table A–1.

Table A–1: State Payment Rates for Medical Records Obtained via Paper or Electronic Records Express as of June 2020

State	General Payment Rates Medical Records
Alabama	Flat fee of $18.00
Alaska	Average payment of $35.00 with a range $30.00-$50.00
Arizona	Flat fee of $13.15
Arkansas	Flat fee of $15.00
California	Range $14.05 to $21.60 dependent on number of pages. Medical records and narrative reports from the treating physician or other medical source pay the lesser of: $35.00 (maximum) or billed amount
Colorado	Flat fee of $22.00 (additional $8 payment if received within 5 days of request). $30.00 for a narrative
Connecticut	Payment of $20, if records received in 30 days or less and no payment for records received after 30 days
Delaware	Flat fee of $15.00
District of Columbia	Payment of $25.00, if records received within 20 days; $10.00 if records received after 20 days; and no payment if records received after 60 days
Florida	Flat fee of $14 for all medical evidence. Teacher and speech-language pathologist questionnaires are a flat rate of $16.00.
Georgia	Payment of $15.00; $10.00 per State of Georgia Health Department's service time; and $25.00 for completion of Mental Impairment Questionnaire and Denver Childhood Questionnaire
Guam	Payment of $35.00; $1.00 for Commonwealth of the Northern Mariana Islands first page and $.25 page thereafter; and $25 for Samoa
Hawaii	Payment of $15.60 and $31.20 for completion of psychiatric questionnaire
Idaho	$15.00 for records or narrative reports, or up to $15.00 if billed less than that
Illinois	Flat fee of $20.00
Indiana	Payment of $14.00 for copies of medical records; $40 completion of mental questionnaire; and $25.00 for other questionnaires
Iowa	Payment of $35.00 (or as billed if less than $35.00) and for search fee "no records found"
Kansas	$30.00 per response
Kentucky	Payment up to $15.00
Louisiana	Flat fee of $20.00
Maine	Flat fee of $15.00 (or as billed if less than $15.00)

[1] SSA, *POMS*, DI 11010.545 (February 14, 2017).

[2] Vermont will pay $20 for medical records only if records are received within 16 days of request date.

State	General Payment Rates Medical Records
Maryland	Payment of $15.00 for copies of pertinent history, physical, and treatment records; $35.00 for abstract and physical from treating physician, the physical examination should be within approximately the last 6 months; and $26.00 for abstract and evaluation (within approximately last 6 months) from treating licensed health care provider such as Occupational Therapist, Physical Therapist, Licensed Clinical Social Worker
Massachusetts	Payment of $15.00 for report to physician; $10.00 for report to hospital (additional $10 payment if received within 15 days of request)
Michigan	Flat fee of $15.00
Minnesota	Payment of $35.00 for all medical or psychological records; $10.00 for chiropractic, audiology, or physical therapist records; and $0 for school, prison, Veterans Administration, or other Government agency records
Mississippi	Payment of $14.00; $16.00 for mental health centers; and $31.00 for functional data reports from mental health centers
Missouri	Payment of $26.06 plus $0.60 per page for paper records plus $24.40 if records maintained off-site; $26.06 + $0.60 per page or $114.17 maximum, whichever is less, for electronic records; and $26.06 plus $1.00 per page for Microfilm
Montana	Payment of $10.00 for hospital and schools and $25.00 for doctors, clinics, mental health centers, private entities (payments limited by state law)
Nebraska	Payment of $20.00 for medical records plus $0.50 per page with specific sources having a max of $100.00; Howard County Hospital - $100 cap up to 500 pages—anything over 500 pages, State will pay $0.50 per page; and $30.00 maximum for Narrative reports
Nevada	Flat fee of $15.00
New Hampshire	Payment of $1.00 per page up to $15.00 maximum for a copy of existing record and $16.00 for narrative or completion of forms
New Jersey	Flat fee of $10.00
New Mexico	Flat fee of $18.75, (will pay less if billed less).
New York	Flat fee of $10.00
North Carolina	Flat fee of $15.00
North Dakota	Payment of $20.00 for the first 25 pages, then $0.75 for each additional page for paper records; and $30 for first 25 pages, then $0.25 for each additional page for electronic records
Ohio	Payment of $15.00 for hospital records and $20.00 for doctor records
Oklahoma	Flat fee of $18.00
Oregon	Payment of $75.00 for full narrative reports more than 2 pages; $35.00 for brief narrative reports; $18.00 for hospitals, doctors and copy companies, 1-10 pages and $0.25 for pages 11-20 and $0.10 for pages 21 and greater with a total maximum fee of $22.50; and $18.00 if there is no indication of the number of pages (additional $5 payment if received within 7 days of request)
Pennsylvania	Flat fee of $29.19
Puerto Rico	Flat fee of $25.00 for all records from non-government entities received within 40 days from original request date
Rhode Island	Payment of $10.00 (additional $5 payment to hospitals if received within 15 days of request); and $0 for hospitals at the reconsideration level[3]
South Carolina	Flat fee of $20.00
South Dakota	Payment of $11.79 for first 25 pages and $.50 for each additional page to a maximum of $35.00; and $25 for narrative reports
Tennessee	Payment of $20.00 for medical records and $0 for school records
Texas	Flat fee of $18.00

[3] If a claimant disagrees with the initial disability determination, he/she can appeal it. 20 C.F.R. § 404.900(a) and 416.1400(a).

State	General Payment Rates Medical Records
Utah	Payment of $15.00 for copy of records; $28.00 for written summary within 12 days; and $0 for records received after 60 days and for records from schools or Government agencies
Vermont	A provider cannot charge for a copy of a disability applicant's medical records. Payment of $20 expedite fee is paid if the records are sent and the invoice is dated within 16 days of request date
Virginia	Flat fee of $15.00
Washington	Payment of $22.00 for photocopied records up to 20 pages, $.50 per page beyond 20 pages and $22 search fee for "no records found"
West Virginia	Flat fee of $11.00
Wisconsin	Flat fee of $26.00
Wyoming	Payment of $15.00 for hospital records; $25 for doctors/clinic and child development centers; and $0 for public school records

Appendix B – Prior Report Recommendation Status

In our May 2015 report, *The Social Security Administration's Expansion of Health Information Technology*, we concluded that, despite challenges, the Agency continued expanding health information technology (IT).[1] Table B–1 shows the status of the recommendations.

Table B–1: Prior Audit Recommendation Status

Recommendation	Status/Resolution
Continue to solicit, on a regular basis, disability determination services' (DDS) user feedback in Medical Evidence Gathering and Analysis through Health Information Technology (MEGAHIT) enhancements	In December 2015, the Social Security Administration (SSA) implemented a communications plan that collects and monitors recommendations from the regions/DDS' via surveys and a discussion board. SSA will continue conducting periodic surveys to solicit feedback. We obtained and reviewed documentation of 11 enhancements SSA made to MEGAHIT software.
Enhance procedures to maintain and update MEGAHIT partner data, such as addresses.	As of April 2016, SSA was holding monthly meetings with health IT partners to allow for partner updates as needed. We obtained and reviewed SSA's health IT onboarding flowchart, its communications plan, and the call script SSA's employees follow for reaching out and obtaining information from health IT partners. SSA meets weekly with partners that are in the onboarding process to collect fiscal documents, facility lists, contact information, and the status of electronic medical record system configuration. Once a partner transitions to production, SSA schedules regular monthly or quarterly touchpoint meetings. The partners discuss their upgrade plans, such as changes to facility lists (including any facilities that need to be added, removed or have address changes). SSA also verifies how the exchange is working and asks the partners if they have any feedback issues, concerns, or upcoming maintenance plans.
Enhance methods to improve the use of information received via health IT.	As of October 2016, SSA was implementing a process to obtain recommendations from health IT partners and meet regularly to discuss enhancements.

[1] SSA, OIG, *The Social Security Administration's Expansion of Health Information Technology, A-01-13-13027* (May 2015).

Recommendation	Status/Resolution
Increase health IT partners—taking advantage of nation-wide Federal efforts led by Health and Human Services' Office of the National Coordinator for Health IT.	SSA coordinates with the Health and Human Services' Office of the National Coordinator for Health IT (HHS-ONC). In addition, SSA collaborates with the Departments of Veterans Affairs and Defense on outreach to potential new health IT partners. SSA also participates in public/private workgroups to ensure that its business needs are considered and incorporated into national policies and standards; and to gather healthcare organization contacts to partner with SSA. We obtained active partner information from SSA's internal website and determined what year the partner was added as a participant in the health IT network. Since our 2015 report, SSA added 171 health IT partners. We interviewed staff at the HHS ONC and reviewed information on issues, such as inoperability, with increasing health IT records.

Appendix C – SCOPE AND METHODOLOGY

To accomplish our objective, we:

- Reviewed applicable sections of the *Social Security Act* as well as the Social Security Administration's (SSA) regulations, rules, policies, and procedures.
- Reviewed prior SSA Office of the Inspector General and Government Accountability Office reports related to electronic medical records.
- Analyzed actions SSA took to implement recommendations from our May 2015 report on *The Social Security Administration's Expansion of Health Information Technology, A-01-13-13027*.
- Reviewed information on SSA's procedures to obtain medical records and use of data analytics to evaluate medical records as well as the sources and quantity of medical records.
- Examined SSA's health information technology (health IT) performance and strategic targets.
- Interviewed employees at the Department of Health and Human Services, Office of the National Coordinator for Health IT, about the nation-wide expansion of electronic health records.
- Interviewed an SSA subject-matter expert on increasing electronic medical evidence.
- Obtained SSA's payment rates to States for medical records.
- Obtained a file of 1,700,177 individuals whose electronic folder indicated SSA requested health IT records in Calendar Years 2016 through 2018. We randomly sampled 275 cases[1] and:
    - analyzed health IT requests on case determinations and case adjudication levels;
    - determined whether SSA's Medical Evidence Gathering and Analysis through Health Information Technology (MEGAHIT) requests were successful;
    - verified that SSA partners responded to MEGAHIT requests an average of less than 1 day; and
    - calculated case processing times.

[1] To conduct this review, we used a simple random sample statistical approach. This is a standard statistical approach used for creating a sample from a population completely at random. As a result, each sample item had an equal chance of being selected throughout the sampling process, and the selection of one item had no impact on the selection of other items. Therefore, we were guaranteed to choose a sample that represented the population, absent human biases, and ensured statistically valid conclusions of, and projections to, the entire population under review. Our sampling approach for this review ensures that our reported projections are statistically sound and defensible.

We conducted our review between April 2020 and August 2021 in Boston, Massachusetts, and Arlington and Falls Church, Virginia. We determined the data used for this audit were sufficiently reliable to meet our audit objectives.

We assessed the significance of internal controls necessary to satisfy our objective. This included an assessment of the five internal control components, control environment, risk assessment, control activities, information and communication, and monitoring. In addition, we reviewed the principles of internal controls associated with our objective. We identified the following components and principles as significant to the objective.

Component 5: Control Activities

Principle 10: Design Control Activities

Principle 12: Implement Control Activities

Component 5: Monitoring

Principle 16: Perform Monitoring Activities

The primary entity audited was the Office of Health Information Technology under the Deputy Commissioner/Chief Information Officer, Systems. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix D – Timeline of the Social Security Administration's Use of Health Information Technology

The Social Security Administration (SSA) began obtaining and analyzing health information technology (health IT) medical records in 2008. Since then, the Agency has expanded its efforts to electronically obtain and analyze medical records, see Table D–1.

Table D–1: Timeline of SSA's Efforts to Electronically Obtain and Analyze Medical Records

Year(s)	Status
2008	Medical Evidence Gathering and Analysis through Health Information Technology (MEGAHIT) system implemented to obtain and analyze health IT medical records.
2009	SSA partnered with MedVirginia—a coalition of not-for-profit hospitals and physicians—to expand the use of health IT to exchange records through the Nationwide Health Information Network.
2011-2015	SSA added 36 health IT partners (through February 2015).[1]
2015	SSA expanded to 38 health IT partner organizations in 30 States and the District of Columbia and identified ways of enhancing health IT case processing and data analytics.
2017	From Fiscal Years 2014 through 2017, SSA met its performance target to increase the percent of initial disability claims processed with health IT medical records.
2018	SSA began developing and testing the Intelligent Medical-Language Analysis GENeration (IMAGEN) application, which would automate the analysis of medical record content and provides decisional support to disability adjudicators. SSA changed its performance target by combining health IT with Electronic Records Express (ERE) medical records because it no longer believed the health IT performance measure accurately represented its performance in reference to the rate of electronic evidence received. (ERE allows organizations to upload records directly into the claimant's unique SSA electronic folder via SSA's secure Website using a barcode SSA provides.)
2020	SSA's Office of Retirement and Disability Policy/Office of Disability Policy submitted an electronic evidence acquisition proposal with a key priority to obtain medical records in electronic and structured data formats.
2021	SSA leadership is reevaluating the electronic evidence acquisition proposal due to a budget reduction. SSA expanded to 209 health IT partners in 49 States. SSA has no plans to create any new targeted business rules to analyze health IT records in MEGAHIT. SSA continued to test and rollout IMAGEN at its offices.

[1] For a list of the health IT partners as of February 2015, see Appendix B in SSA, OIG, *The Social Security Administration's Expansion of Health Information Technology, A-01-13-13027* (May 2015).

Appendix E –Summary of Federal Health Information Technology Legislation

Table E–1 summarizes Federal health information technology (health IT) legislation.

Table E–1: Summary of Federal Health IT Legislation

Legislation	Summary
Health Information Technology for Economic and Clinical Health Act of 2009[1]	Promoted the adoption and use of health IT and established the Department of Health and Human Services' Office of the National Coordinator for Health IT (HHS-ONC) and other committees in support of this *Act*.
American Recovery and Reinvestment Act of 2009[2]	Paid approximately $1 million per contract for organizations to implement electronic record systems and provided that up to $40 million to be used by the Social Security Administration for health IT research and activities to facilitate the adoption of electronic medical records in disability claims.
Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015[3]	Established the national objective to achieve widespread interoperability with certified electronic health records and required the Department of Health and Human Services to measure the extent to which this objective is being met.
21st Century Cures Act[4]	Defines interoperability and mandated the HHS-ONC develop or support a trusted exchange framework for trust policies and practices and for a common agreement for exchange between health information networks.
Coronavirus Aid, Relief, and Economic Security Act[5]	In an attempt to improve public health infrastructure, the HHS-ONC will distribute $2.5 million in CARES Act funding to health information exchanges to support public health uses of information from health information exchanges. These networks make it easier for health care organizations to exchange information, ranging from case summaries to hospital discharge data.

[1] *Health Information Technology for Economic and Clinical Health Act*, Pub. L. No. 111-5, § 3001 (a), 123 Stat. 115, 230 (2009).

[2] *American Recovery and Reinvestment Act of 2009*, Pub. L. No. 111-5, 123 Stat. 115, 186 (2009).

[3] *Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015,* Pub. L. No. 114-10, 129 Stat. 87, 139 (2015).

[4] *21st Century Cures Act*, Pub. L. No. 114-255, § 4003, 130 Stat. 1033, 1160 (2016).

[5] *Coronavirus Aid, Relief, and Economic Security Act*, Pub. L. No. 116-136, 134 Stat. 281 (2020).

Legislation	Summary
21st Century Cures Act: Interoperability, Information Blocking, and the Office of the National Coordinator Health IT Certification Program Final Rule[6]	HHS-ONC is responsible for the implementation of key provisions in Title IV of the *21st Century Cures Act* that are designed to advance interoperability; support the access, exchange, and use of electronic health information; and address occurrences of information blocking.[7]

[6] *21st Century Cures Act*, 85 Fed. Reg. 25642, pp. 25642-25961 (2020).

[7] Information blocking is a practice by a health IT developer of certified health IT, health information network, health information exchange, or health care provider that, except as required by law or specified by the Secretary of Health and Human Services as a reasonable and necessary activity, is likely to interfere with access, exchange, or use of electronic health information.

Appendix F– AGENCY COMMENTS

SOCIAL SECURITY

MEMORANDUM

Date: 12/27/2021 Refer To: TQA-1

To: Gail S. Ennis
Inspector General

From: Scott Frey
Chief of Staff

Subject: Office of the Inspector General Draft Report - "The Social Security Administration's Expansion of Health Information Technology to Obtain and Analyze Medical Records for Disability Claims" (A-01-18-50342) — INFORMATION

Thank you for the opportunity to review the draft report. We agree with the recommendation.

Please let me know if I can be of further assistance. You may direct staff inquiries to Trae Sommer at (410) 965-9102.

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