DOCUMENT RESUME

NOT

AVAILABLE

REPORT BY THE

Comptroller General

OF THE UNITED STATES

A Plan For Improving The Disability Determination Process By Bringing It Under Complete Federal Management Should Be Developed

The Federal disability insurance program and the Supplemental Security Income program in 1977 paid about $14.0 billion to about 6.7 million beneficiaries.

Under the present Federal-State arrangement, the Social Security Administration cannot exercise direct managerial control of the activities of the State agencies making disability decisions. This, with other uncorrected weaknesses in the disability determination process, provides no assurance that a reasonable degree of uniformity and efficiency will be achieved in these ever growing, very costly disability programs.

The Secretary of Health, Education, and Welfare should develop, for consideration by the Congress, a plan for strengthening the disability determination process by bringing it under complete Federal management so that the Social Security Administration can acquire the control needed to properly manage the programs. He should also direct the Commissioner of Social Security to continue work to improve the quality and management of the disability determination process.

HRD-78-146

AUGUST 31, 1978

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(4)

The Honorable James A. Burke
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

In response to your letter of January 5, 1977, we reviewed the present Federal/State arrangement and the efficacy of actions proposed and/or taken by the Social Security Administration to correct the weaknesses in its quality assurance system.

We identified weaknesses which precluded the Social Security Administration from exercising direct managerial control of the activities of the State agencies making disability decisions. This, along with other uncorrected weaknesses in the disability determination process, provides no assurance that a reasonable degree of uniformity and efficiency will be achieved in the programs.

As requested by your office, we did not take the additional time to obtain written comments from the Department of Health, Education, and Welfare. The matters covered in the report, however, were discussed with Social Security Administration personnel and their comments are incorporated where appropriate.

As agreed with your office, we are sending copies of this report to the House Committee on Government Operations, the Senate Committee on Governmental Affairs, the House and Senate Committees on Appropriations, the Director of the Office of Management and Budget, and the Secretary of Health, Education, and Welfare. Copies will be made available to other interested parties who request them.

Sincerely yours,

Comptroller General
of the United States

REPORT BY THE
COMPTROLLER GENERAL
OF THE UNITED STATES

A PLAN FOR IMPROVING THE DISABILITY DETERMINATION PROCESS BY BRINGING IT UNDER COMPLETE FEDERAL MANAGEMENT SHOULD BE DEVELOPED

D I G E S T

The Social Security Act, as amended, intended that persons applying for disability benefits receive objective and uniform consideration of their claims. The most important step in the claim consideration process is determining whether a claimant is disabled. That decision is usually made by 1 of the 54 State agencies under contract with the Department of Health, Education, and Welfare (HEW). The function of each State agency in the disability determination process is the same--rendering decisions as to whether or not a claimant is disabled. However, the means used to reach these decisions differ considerably among the States. Because of this and the inherent subjectivity of decisionmaking, total uniformity of decisions may never be achieved.

Every claim approved by a State agency commits large amounts of either disability insurance trust funds or general revenue funds. The Federal disability programs--the Social Security Disability Insurance program and the Supplemental Security Income program--under the Social Security Act are large and important. In 1977 about 6.7 million disability beneficiaries received disability benefits of about $14.0 billion. (See p. 3.)

Under the existing Federal/State arrangement, the Social Security Administration cannot exercise direct managerial control of the activities of the State agencies. This circumstance, together with Social Security's failure to correct other weaknesses in the disability determination process, provides no assurance that a reasonable degree of uniformity and efficiency will be achieved in these ever-growing, very expensive programs.

The disability program was to be linked with an effective State vocational rehabilitation program. However, from 1967 to 1976, only 20,000 workers were reported as rehabilitated and terminated from the disability insurance rolls. During this time the disabled workers on the rolls increased by 1 million. In addition, many terminations which had been reported were of beneficiaries who had medically recovered and returned to work without the services of a rehabilitation agency. Thus, very few beneficiaries have been rehabilitated and removed from the disability rolls as a result of efforts by State vocational rehabilitation agencies.

Therefore, the original reason for having the Federal/State relationship is no longer completely valid. (See p. 5.) Social Security's efforts to strengthen the present Federal/State agreements have met with little or no success principally because many State officials are unwilling to relinquish prerogatives accorded the States under the present agreements--such as determining their own organizational makeup, workflow processes, and training programs. (See pp. 6 and 9.)

In response to GAO's earlier recommendations 1/ to alleviate the above kinds of problems, an amended agreement was proposed and submitted to the States by Social Security in July 1977. This proposed agreement expanded the role of Social Security and the Secretary of HEW to ensure uniformity. Only 5 of the 39 States that commented on the proposal said they would sign the new

---

1/See our report entitled "The Social Security Administration Should Provide More Management and Leadership in Determining Who Is Eligible for Disability Benefits," (HRD-76-105, Aug. 17, 1976).

agreement; 34 States disapproved of some portion of the proposal. Further revisions were made to the agreement and it was again discussed by State representatives in February 1978. Objections, similar to those voiced against the earlier version, were heard and no action was taken. (See p. 8.)

GAO believes the present Federal/State relationship is an impediment to improving the administration of the programs because of the (1) unanswered questions about the effectiveness and efficiency in the Federal/State relationship that have existed for almost 20 years; (2) questionable need for the process to be closely alined with the State vocational rehabilitation activities; (3) inability of the principals to remedy contractual defects, such as clearly defining their responsibilities; and (4) need for Social Security to have more effective management and control over the disability programs. (See p. 10.)

The quality and uniformity of disability decisions continue to suffer because Social Security has not fully corrected the weaknesses that GAO reported in August 1976. The Social Security Administration agreed with GAO's recommendations and has been working to implement them, but more effort is needed. So far, Social Security has not

--provided timely, clear, and concise criteria and guidelines for the States to use in making disability decisions (see pp. 12 to 14);

--assured that uniform training was provided to State agency employees (see pp. 14 and 15); and

--assured that an effective quality assurance system is properly implemented. (See pp. 15 to 24.)

In addition, during this review, GAO found that Social Security had not made sure there was adequate participation of physicians in the disability determination process.

The agreements between the Secretary of HEW and the State agencies provide that the determination of disability shall be made by a medical consultant and other individual qualified to interpret and evaluate medical reports relating to physical or mental impairments. However, time, everchanging procedures, and instructions, and somewhat passive central management by Social Security have joined to defeat this provision.

The physician participation in the disability decisionmaking process varied greatly among State agencies and among physicians within the same State agency. (See pp. 24 and 25.)

These weaknesses will have to be corrected if there are to be assurances that--to the extent possible--all disability claims can be processed uniformly and efficiently.

Since GAO's August 1976 report, Social Security has committed substantial resources for implementing an acceptable quality assurance system. Actions taken by Social Security included:

--Issuing a comprehensive message to regional offices on strengthening the State agencies' quality assurance activities and functions.

--Establishing standards for use in measuring timeliness and accuracy of State agency decisions.

--Further refinement of the standardized classification system for defining errors and/or deficiencies.

--Redesigning reports to provide users with more definitive data.

--Adding additional categories of deficiencies that are returned to the State agencies for further consideration.

--Implementation of a nationwide automated quality assurance data collection system.

--Work on an automated system for selecting sample cases for quality assurance review.

State agency and regional office officials said that these actions should help to improve quality and provide better feedback throughout the system. However, they said this would not correct all the problems with the present system and that it was too early to tell if quality has been improved. (See p. 24.)

The Secretary of HEW should develop, for consideration by the Congress, a plan for strengthening the disability determination process by bringing it under complete Federal management so that the Social Security Administration can achieve the control needed to properly manage the disability programs.

The Secretary should also direct the Commissioner of Social Security to continue work on:

--Assuring that clear, concise criteria and guidelines are provided for use in making disability determinations.

--Providing uniform training for those making the disability determinations.

--Assuring that the quality assurance system is properly implemented.

--Assuring that there is adequate participation by physicians in the disability determination process. (See p. 27.)

As requested by the Subcommittee, GAO did not take the additional time to obtain written comments on this report. However, the matters covered in the report were discussed with Social Security Administration personnel and their comments are incorporated where appropriate.

Contents

ABBREVIATIONS

A&E	Analysis and Evaluation Unit
CRS	Case Review Section
CSAVR	Council of State Administrators of Vocational Rehabilitation
DI	Social Security Disability Insurance
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
OMB	Office of Management and Budget
SSA	Social Security Administration
SSI	Supplemental Security Income

CHAPTER 1

INTRODUCTION

The Social Security Administration (SSA) administers two programs under which disabled persons may be entitled to receive benefits:

--The Social Security Disability Insurance (DI) program, established in 1954 under title II of the Social Security Act, to prevent the erosion of retirement benefits of wage earners who become disabled and were unable to continue payments into their social security account. In 1956 the program was expanded to authorize cash benefit payments to the disabled.

--The Supplemental Security Income (SSI) program, established under title XVI of the Social Security Act, to provide cash assistance to needy aged, blind, and disabled persons. Effective January 1, 1974, the program replaced the former federally assisted but State-administered programs of Old-Age Assistance, Aid to the Blind, and Aid to Permanently and Totally Disabled.

To be considered eligible for DI benefits, a worker must be fully insured for social security retirement purposes and generally have at least 20 quarters of coverage during the 40-quarter period ending with the quarter in which the disability began. The Social Security Act benefit schedule, as of June 1976, provides benefits ranging from a monthly minimum of $121.80 for an individual and $182.70 for a family, to a maximum of $695.40 for an individual and $1,216.90 for a family. Maximum benefits can be reached only in unusual circumstances.

The Congress established a separate Disability Insurance Trust Fund to specifically identify the costs of the DI program. A specified percentage of social security payroll tax receipts are deposited into this fund and all disability insurance benefit payments and associated administrative costs are disbursed from it.

The SSI program, financed from Federal general revenues, is intended to provide a minimum income for eligible persons using national eligibility requirements and benefit criteria. An individual's eligibility for benefits under this program is subject to certain limitations on amounts of income and resources. Social security coverage is not a prerequisite for

eligibility. As of July 1978, the SSI program guarantees a monthly income of $182.70 for a qualified individual with no countable income and $284.10 per month for a couple.

The statutory definition of disability under the DI and SSI programs is substantially the same. Disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months. Substantial gainful activity is any level of work performed for remuneration or profit that involves significant physical or mental duties, or a combination of both. Work may be considered substantial even if it is performed part time and is less demanding, responsible, or pays less than the individual's former work. Presently, income of $240 a month is used as a guideline for determining substantial gainful activity.

A claimant can apply for disability benefits at any social security district or branch office. Applications are processed by claims representatives who interview the applicant and prepare disability and vocational reports for use by State agencies.

The determination of an applicant's disability is made by a State agency whose primary function is to develop medical, vocational, and other necessary evidence and then evaluate it and make a decision. The State agency uses the disability and vocational report prepared by the social security district or branch office to determine what additional information must be obtained to fully develop a claim so that a decision can be made.

The criteria used for making the disability determination and guidelines for developing and processing claims are furnished to the State agency by SSA.

The State agencies carry out the disability determination process under agreements with the Department of Health, Education, and Welfare (HEW). The costs incurred in making disability determinations are borne by the Federal Government.

Unlike grant-in-aid programs, the Federal/State relationship is a contractual one requiring no implementing State legislation. State laws and practices control many administrative aspects of the disability determination process because the personnel involved are State employees.

Between fiscal years 1972 and 1977 (title XVI became effective in 1974), the number of claims, the amount of benefits paid, and the administrative costs of the two programs increased significantly. Beneficiaries increased from about 3.1 million to about 6.7 million, benefits paid increased from about $4.0 billion to about $14.0 billion, and administrative costs of the State agencies increased from about $68.2 million to about $254.2 million. The number of State agency employees increased from about 4,400 to about 9,400. The following chart shows the growth of the program.

	Disability programs					
		Benefits paid during year			Program administration by State agencies	
Fiscal year	Beneficiaries (end of year) Titles II & XVI	DI Trust Fund	SSI general revenue	Total	Cost	Employees
	(millions)	(billions)			(millions)	(thousands)
1972	3.1	$ 4.0	$ -	$ 4.0	$ 68.2	4.4
1973	3.4	5.2	-	5.2	80.4	6.3
1974 (note a)	5.2	6.2	.8	7.0	146.8	10.3
1975	6.0	7.6	2.3	9.9	206.8	10.1
1976	6.5	9.2	2.6	11.8	228.3	9.3
1977	6.7	11.1	2.9	14.0	254.2	9.4

a/Payment of SSI benefits started in January 1974.

OBJECTIVES AND SCOPE OF REVIEW

Our review, which was requested in January 1977 by the Chairman of the Subcommittee on Social Security, House Committee on Ways and Means, was primarily directed at determining (1) whether the present Federal/State arrangement lends itself to or is an impediment to bringing about necessary changes to improve the disability determination process and (2) the efficacy of actions proposed and/or taken by SSA to correct the weaknesses in its quality assurance system, as discussed in our previous report. 1/ We also followed up on the status of other recommendations in that report.

Our review was conducted at SSA headquarters in Baltimore; SSA regional offices in Atlanta, Denver, New York, Philadelphia, San Francisco, and Seattle; and State disability determination units in Alabama, California, Colorado, Kentucky, New York, Virginia, and Washington.

1/"The Social Security Administration Should Provide More Management and Leadership in Determining Who Is Eligible for Disability Benefits," (HRD-76-105, Aug. 17, 1976).

CHAPTER 2

THE EXISTING FEDERAL/STATE RELATIONSHIP IS AN IMPEDIMENT TO IMPROVING THE ADMINISTRATION OF THE DISABILITY PROGRAMS

The most important step in the claim consideration process is determining whether a claimant is disabled. That decision is usually made by 1 of the 54 State agencies under contract to HEW. The function of each State agency in the disability determination process is the same--rendering decisions as to whether or not a claimant is disabled. However, the means used to reach these decisions differ considerably among the States. Because of this and the inherent subjectivity of decisionmaking, total uniformity of decisions may never be achieved.

Every claim approved by the State commits large amounts of either disability insurance trust funds or general revenue funds. SSA estimates that, on the average, each approved disability insurance claim results in the eventual payment of $29,000 in benefits. A similar estimate is not available for SSI benefits.

Under the existing Federal/State arrangement, SSA cannot exercise direct managerial control of the activities of the State agencies. This circumstance, together with SSA's failure to correct other weaknesses in the disability determination process, as discussed in chapter 3, provides no assurance that a reasonable degree of uniformity and efficiency will be achieved in these ever-growing, very expensive programs.

It was determined that the disability decisions should be made by the State vocational rehabilitation agencies. In this regard, the Social Security Act gave the Secretary of HEW authority to contract with State agencies to determine claimants' disability. At the present time, agreements are in effect with 54 1/ State agencies. In 39 States, units of the rehabilitation agencies generally carry out this function.

1/There is one State agency in each State, the District of Columbia, Puerto Rico, and Guam, and a separate agency for the blind in South Carolina.

It was believed that this arrangement would better serve the dual purpose of encouraging rehabilitation of disabled persons and offering the advantages of the medical and vocational case development already being routinely undertaken by State rehabilitation agencies.

However, during 1967 to 1976, only 20,000 workers were reported as rehabilitated and terminated from the disability insurance rolls. During this time the disabled workers on the rolls increased by 1 million. In addition, many terminations which had been reported were of beneficiaries who had medically recovered and returned to work without the services of a rehabilitation agency. Thus, very few beneficiaries have been rehabilitated and removed from the disability rolls as a result of efforts by State vocational rehabilitation agencies.

Therefore, linking the State Vocational Rehabilitation Service with the Disability Insurance program no longer furnishes adequate justification for State involvement. Since the inception of the disability insurance program, questions have been raised about the effectiveness and efficiency of the Federal/State arrangement in providing uniform and equitable methods for determining disability. It was questioned by the Harrison Subcommittee 1/ and us as early as 1959, and as recently as March 1978 in reports prepared by the staff of the Subcommittee on Social Security. In our August 1976 report, we identified several weaknesses in the administration of the disability determination process that could adversely affect the uniformity of decisions. We recommended the Federal/State agreements be reviewed and that revisions be made to clearly define the responsibilities of both SSA and the State agencies consistent with a uniform disability determination process. We pointed out that SSA needed to take a stronger and more active leadership role in its management of the disability program to correct identified weaknesses. We also said that the States should recognize the need for a stronger and more active leadership role by SSA and cooperate in its adoption.

1/Special House Subcommittee on Social Security formed to study the SSA Disability Program during 1959 and 1960.

At that time we believed the present Federal/State relationship could work if such actions were taken by SSA and the States.

However, since our August 1976 recommendation, SSA efforts to strengthen the present Federal/State agreements have met with little or no success. Many State officials are unwilling to relinquish prerogatives accorded the States under the present agreements--such as determining their own organizational makeup, workflow processes, and training programs.

RESTRICTIONS IMPOSED BY STATES

In August 1976 we reported that even though the agreements preclude the States from imposing restrictions which would be detrimental to the programs, some States had done so. Because of the nature of the State agencies--they are staffed by State employees--certain State laws and practices, although not necessarily detrimental to other State components, tend to create problems. Some States exert control over hiring practices, use of overtime, out-of-State travel, equipment justification, budget preparation, and staffing ratios.

Similar conditions exist today. For example, one State restricts all out-of-State travel. One official's travel to meet with SSA and other State agencies was denied by the State agency's parent organization on the grounds that the travel would not directly benefit the State. Another State agency's out-of-State travel must be approved in advance by its parent organization.

In one State equipment purchases must be approved by the State purchasing department. Because of that requirement, it took that State agency months, after SSA had approved the purchase, to acquire much needed telerecording equipment.

In August 1976 we reported that the location of the State agency in the State government organizational structure was significant when considering the possible adverse effects local politics and changes in the State administration may have had on the stability and autonomy of the unit. State laws and practices influenced and controlled many administrative aspects of this Federal program. Since the personnel were State employees, they received direction from various levels of the State government. Similar conditions exist today. For example, in one State, legislation was pending

that would reorganize the State agency's parent department. During the legislative debate on the reorganization, arguments were made by two other departments that the State agency should be retained with them. State agency officials told us the reason these departments wanted to control it was because about $5 million a year in indirect costs would accrue to them as the parent organization.

As the result of the failure of the legislature in another State to provide adequate funds for operation of the parent department of one State agency, the Director threatened to close the parent department and lay off employees for a 6-week period. The Director recognized that the federally funded State agency would have to continue to operate. However, State personnel policy provided that persons certified for a position could "bump" persons with less seniority during layoffs. As a result, senior clerical staff from within the department could have displaced agency personnel with less service. SSA regional officials said that action would have been unacceptable and have a crippling effect on the disability program. These officials said if the layoffs and bumping had taken place they would have recommended closing the State agency and having the disability claims adjudicated by the SSA regional office. Neither action took place because the State legislature ultimately provided the necessary funds and the threatened layoff was not implemented.

The jobs of some State agency directors are protected under State civil service. Others are political appointees whose jobs are subject to changes in administrations. A reorganization within the parent department left one State agency without a director. The acting director was instructed not to make any changes in operations or personnel. The director's position remained vacant for about 13 months while the head of the parent department pushed a bill through the State legislature making it subject to political appointment. We were informed by State agency officials that during this period there was general apathy among the staff, poor morale, and at times, open rebellion.

One State agency's parent organization is the State's welfare department. This creates a conflict between the roles and objectives of the State welfare and Federal disability programs. The parent agency wants to reduce the State welfare rolls in order to reduce the expenditure of State moneys. The State agency director said he probably would be discharged if he followed a strict interpretation of SSA guidelines for determining disability because it

would result in more claims being denied. More individuals would then be eligible for State welfare payments. As a result, the State agency is pressured into approving disability claims paid with Federal funds.

In another State agency there is a strong anti-Federal atmosphere. The prevailing attitude is:

> "We are State employees, therefore, we don't have to pay attention to what the SSA regional office * * * or any other Federal agency says."

Although in some cases the restrictions imposed by the States may be insignificant, in other instances they hinder the efficient and economical operation of the disability programs.

STATE OPPOSITION TO PROPOSED CHANGES IN THE FEDERAL/STATE AGREEMENT

In response to our earlier recommendations to alleviate the above kinds of problems, an agreement was proposed and submitted to the States by SSA in July 1977. The proposed agreement expanded the role of SSA and the Secretary of HEW to better ensure uniformity. Comments on the proposal were received from 39 States and discussed at a meeting of the Council of State Administrators of Vocational Rehabilitation (CSAVR) in September 1977. Only five of the States responding said they would sign the new agreement. Thirty-four States said they would not sign it because they disapproved of some of its provisions. For example, 14 States had specific objections regarding standards to be issued by the Secretary of HEW and a requirement for conformity; 14 objected to a provision authorizing the Secretary to monitor and evaluate their performance, in accordance with adjudicative and administrative standards; some objected to the Secretary's right to have access to their premises; 7 objected to the Secretary's authority to establish positions and be consulted about personnel standards; and 6 States objected to the Secretary having to approve their facilities, location of offices, and organizational structure. Overall the States generally disapproved increased Federal control.

Accordingly, CSAVR voted to reject the proposed agreement as it was then written. The administrators expressed the opinion that the present Federal/State agreements should be left as is, or the program should be placed under full Federal control.

After the September meeting, a joint task force of SSA and CSAVR officials was established to further revise the proposed agreement to eliminate the State's objections.

The revised version of the agreement was discussed in a CSAVR meeting held February 6 to 8, 1978. At that time formal comments had not been received from the States; however, objections similar to those for the earlier version were voiced by the State officials present. As a result CSAVR voted not to take action on it.

In response to another one of our recommendations, SSA, with the help of State agency representatives, issued a report on a model for State agency organization and workflow. CSAVR emphasized that this model should be interpreted as being just that, and should not be interpreted as a mandate. It also emphasized that the organization level of the disability units must be determined by each State and, where appropriate, by each administrator. CSAVR stated that while it may advise its membership to study the principles and concepts contained in the report it will insist that each State continue to be responsible for adjusting its organizational structure and workflow to meet individual State needs.

Many SSA regional officials agreed the present Federal/State relationship is an impediment to bringing about the changes necessary to better insure that disability claimants receive objective and uniform consideration of their claims regardless of where they are filed. Under the present relationship, States establish their own organizations and set their own performance standards, job classifications, salaries, and hiring practices. These factors vary among the States and affect the quality of employees and supervisors. The quality of personnel has a direct impact on the quality of the decisions rendered.

Under the present agreements, SSA has little authority to enforce Federal policy and procedures, and effect staffing and operational changes except through the review and approval of the State agency budgets. Other than that, SSA regional officials have to rely on "friendly persuasion" or "pressure tactics" to bring about needed changes in State agency operations. Many of these officials believe that putting the disability programs under complete Federal management would result in a simpler, more effective arrangement.

There is a lack of agreement among State administrators on the need for a change. Some believe the Federal Government should only provide the necessary resources to do a proper

job, but take no part in the management of the State organization. Others believe the Federal/State agreements are an impediment to establishing an effective program. In commenting on the Federal/State agreement, one State agency administrator stated:

> "* * * unless Congress clearly defines and clearly specifies what goes into the Federal-State contractual agreement the states will not comply consistently and uniformly to the suggestions and recommendations made by HEW and they will not be penalized for not complying. As it now stands, HEW has no authority to enforce the recommendations which they make. How then can the wishes of Congress be carried out to the fullest extent?
>
> "You must start with the ability to control the direction of management and the operational process. Until this is accomplished, recommendations with regard to the application of vocational factors, improvement in the uniformity and consistency of decision making, etc. cannot and will not be carried out.
>
> "* * * I sincerely believe that until you federalize the program you cannot accomplish your objectives."

We believe the present Federal/State relationship is an impediment to improving the administration of the programs because of the (1) unanswered questions about the effectiveness and efficiency in the Federal/State relationship that had existed for over 20 years; (2) questionable need for the process to be closely alined with the State vocational rehabilitation activities; (3) inability of the principals to remedy contractual defects, such as clearly defining their responsibilities; and (4) need for SSA to have more effective management and control over the disability programs. Accordingly, we believe that the Secretary of HEW needs to develop, for consideration by the Congress, a plan for strengthening the disability determination process by bringing it under complete Federal management.

We recognize that this action will take time to implement. In the interim, there are other weaknesses in the determination process that must be corrected regardless of whether SSA or the States make the disability decisions. These weaknesses are discussed in chapter 3.

CHAPTER 3

MORE IMPROVEMENT NEEDED IN THE DISABILITY DETERMINATION PROCESS

The quality and uniformity of disability decisions continues to suffer because SSA has not fully corrected the weaknesses that we reported in August 1976. SSA agreed with our recommendations and has been working to implement them but more effort is needed. So far, SSA has not

- --provided timely, clear, and concise criteria and guidelines for the States to use in making disability decisions;
- --assured that uniform training was provided to State agency employees; and
- --assured that an effective quality assurance system is properly implemented.

In addition, during this review, we found that SSA had not made sure there was adequate participation of physicians in the disability determination process.

These weaknesses will have to be corrected if there are to be assurances that--to the extent possible--all disability claims can be processed uniformly and efficiently.

LACK OF UNIFORMITY IN THE STATES' DISABILITY DETERMINATIONS

In August 1976 we reported that there was considerable disagreement among the 10 States we reviewed on the disposition of a sample of 221 actual claims which had been adjudicated by a State not included in our review. Where some approved a claim, others denied it; still others said there was insufficient documentation to render a decision.

In our opinion, the disagreement on the disposition of the sample disability claims was, in part, the result of SSA's failure to (1) provide timely, clear, and concise criteria and instructions upon which to render decisions; (2) assure that uniform training was provided to all State agency employees; and (3) provide that its quality assurance system, established to monitor the disability determination process was adequately implemented.

INADEQUATE CRITERIA AND INSTRUCTIONS

In our August 1976 report we stated that the criteria and instructions provided to the State agencies by SSA to use in disability determinations were often incomplete, vague, contradictory, time consuming to implement, and subject to divergent interpretations. In addition, State agencies had been inundated with changes in instructions originating at both SSA headquarters and SSA regional offices and transmitted through a variety of communication channels. This resulted because SSA (1) did not update or revise criteria and instructions on a timely basis; (2) failed to put the changes in an orderly fashion in a manual so that State agencies could have a ready reference; (3) failed to allow enough time for its regional offices and State agencies to review and comment on proposed changes; and (4) did not properly coordinate the issuance of changes by various bureaus within SSA.

As a result, the State agencies had to provide their own interpretations of some instructions and spend excessive time and effort reviewing the various instructions to determine what was current. Thus, with 54 State agencies using their own interpretations of SSA instructions to determine disability, a reasonable degree of uniformity of decisions is difficult, if not impossible, to achieve.

Our review showed that these problems still existed. Some State agency officials told us that problems with the criteria and guidelines represented the biggest obstacle to quality disability determinations. SSA is working toward correcting these problems, but more work is needed for a satisfactory solution.

Medical criteria

The presence of a significant medical impairment is required before an applicant's disability claim can be allowed. SSA formulated a listing of the medical criteria used in evaluating the severity of an applicant's impairment. In August 1976 we reported that this listing had not been updated since 1968, even though the State agencies had expressed concern with several of the criteria. In this review, we found that the listing had still not been updated, although in March 1977 SSA did issue a much needed supplemental listing to be used in evaluating childhood disabilities.

The same problems with the medical criteria that we reported in August 1976 continue. For example, State agency officials said that many terms used to describe impairments in the criteria were still vague. They said such terms as marked, sustained, high, moderate, and repeated were subject to divergent interpretations.

State agency officials also said that many of the criteria were questionable because they were outdated and failed to take into consideration advances in medical technology, or were too time consuming or costly to implement. For example, certain criteria required laboratory tests which were no longer commonly used in the medical community or which required equipment which was not readily available.

State agency officials said that the inadequate medical criteria have adversely affected the quality and uniformity of decisions.

SSA is aware of the problems with the criteria. On two occasions (May 1975 and July 1977) SSA circulated proposed new medical listings for comment. However, neither was issued.

We believe it is imperative that SSA provide clear, reasonable, and timely criteria for making disability determinations. Without such criteria, other attempts to achieve quality disability decisions are of limited value.

Vocational criteria

An applicant who has an impairment which does not meet or equal the severity of the criteria in the medical listing, but is more than a slight impairment, may be determined disabled on the basis of vocational factors such as age, education, and work experience. Many disability claims are decided on these factors.

In our August 1976 report, we reported that the term "slight impairment" had never been properly defined. In addition, SSA had not provided the States with adequate criteria for considering the weight that should be applied to vocational factors in the adjudication process. These deficiencies permitted variances of interpretation among the States and individual claims examiners, and resulted in a lack of uniform treatment for claimants.

Neither of these problems has been remedied, even though SSA attempted to do so. State officials told us that slight

impairment had still not been adequately defined and was still open for interpretation. In addition, amendments to HEW's regulations regarding consideration of vocational factors have been proposed recently and not yet adopted. We believe that reasonably uniform decisions cannot be assured until all the factors to be considered have been adequately defined and weighted in accordance with their importance.

Claims processing instructions

In August 1976 we reported that SSA had been lax in issuing clear and timely instructions to State agencies concerning claims processing. This condition still exists. SSA provided State agencies with a Disability Insurance State Manual which is supposed to give the disability examiners an up-to-date, ready reference on how to process claims. However, SSA had not kept this manual current, thereby limiting its value.

Although SSA had made some attempt to put supplemental instructions in a manual, State agencies continue to be inundated with instructions originating at various sources and transmitted through several communication channels outside the manual. For example, officials in one State agency said they received, in a 6-month period, a minimum of 73 supplements or changes in processing instructions through 8 different communication channels from the SSA central or regional offices.

In addition, State agency officials said that changes in instructions were often untimely, inaccurate, not cross-referenced, and not coordinated between issuing groups within SSA. One State agency official, in a letter to his superior, described one such change as "* * * an abominable accumulation of refuse which, if implemented, would cause near chaos within our case processing units."

LACK OF UNIFORM TRAINING PROGRAMS

We reported that the training provided employees of the State agencies varied greatly in form, content, and length. These differences resulted, in part, because (1) the agreement between the Secretary of HEW and the States gave the State agencies the responsibility for developing and providing training for their employees and (2) SSA did not assure that uniform training was provided. As a result, State agency personnel received varying degrees of training on the technical and medical requirements necessary to uniformly and efficiently adjudicate claims.

SSA still has not provided the States with a uniform program for training State agency employees; however, it has made substantial progress toward developing a basic training program for disability examiners. SSA has made extensive efforts to complete this new training package in each of seven program segments. Although there is much work to be done on this package, it is scheduled for release in December 1978. In addition, SSA has replaced outdated portions of an existing training program and has distributed to the State agencies: (1) a training package on vocational factors, (2) an orientation package for State agency physicians, and (3) a training resources catalog.

Most State agency and SSA regional office officials looked favorably upon these efforts, but agreed that a nationwide training program was still needed. In an attempt to fill the present void, at least one SSA regional office has developed and now administers a training program for State agency claims examiners.

QUALITY ASSURANCE SYSTEM STILL NEEDS IMPROVING

SSA has established a three-tier quality assurance system which is supposed to assure uniform application of disability standards among the State agencies and the SSA regional and central offices. The objective of this system is to (1) identify problems related to individual examiners, State agencies, and the entire disability determination system and (2) provide feedback to the proper levels so that corrective action can be taken. Before this system can function properly and achieve its intended results, it has to be properly established and implemented at all three levels involved.

In August 1976 we reported that the quality assurance system, as implemented, provided little assurance that problems related to the disability determination process were identified and that corrective action would be taken. Accordingly, the system was not achieving its objective of assuring program uniformity nationwide.

In this review we found that the quality assurance system was still not fully effective because

--the system was not functioning at all levels;

--the feedback from all levels within the system was still inadequate, thus, the trend analysis and special studies intended to correct systemwide problems were still not fully implemented; and

--there was inconsistent application of SSA guidelines and criteria at different levels of review.

Additionally, in April 1978 we reported 1/ that although the quality assurance system covers initial disability determinations, reconsiderations of previously denied applicants, and SSI and DI cases having a medical diary, 2/ it does not cover recipients who are not covered by a medical diary. It does not evaluate the adequacy of the guidelines for establishing medical diaries or if the guidelines are achieving their intended purpose--identifying those recipients whose impairments improve.

SSA has committed substantial resources for implementing an acceptable quality assurance system. We realize it takes time to complete such an undertaking and although progress has been made, much remains to be done.

Three-tier quality assurance system

Before the implementation of the three-tier quality assurance system in 1974, SSA conducted a preadjudication review of most State agency disability determinations. Questioned cases were returned to the State agencies for review and reconsideration.

SSA changed from the 100-percent review because it believed that there had been a leveling off of the rate of progress of the State agencies in improving the quality of their disability determinations. It tried to devise a more efficient and effective quality assurance system based on a sample review of claims. Under this concept, the States were to accept more responsibility for self-assessment and improvement in the quality of their work. SSA believed that sharing this responsibility with the States would produce better results than continuing the 100-percent review. It further believed that the sample system would give it an adequate check of State agency operations and allow for more substantive policy guidance by its review and comments on a smaller number of cases.

1/Our report (HRD-78-97, Apr. 18, 1978) is included as appendix III.

2/A future medical reexamination date is called a medical diary.

Since 1974 SSA has used a three-tier quality assurance system for monitoring the quality of State agencies' disability decisions. The first tier is a 15-percent preadjudicative sample review which is supposed to be conducted nationwide by quality assurance units in the State agencies. The second tier consists of a 5-percent postadjudicative sample review by the SSA central office for title II claims and a 7-percent review by the SSA regional offices for title XVI claims, including those with concurrent title II claims. The sample claims reviewed by SSA are preselected by a computer and forwarded by the SSA district offices. When SSA officials explained this system to the Congress in 1974 they said the third tier was supposed to be an end-of-line review and appraisal by SSA's central office to monitor and evaluate the entire claims process, and focus on the assessment of national trends and the overall effectiveness of policies and procedures. However, the third-tier review, as implemented, consists of a central office review of a sample of title XVI claims previously reviewed by the regional offices. The present system has never provided, nor does it now provide, for an overall monitoring or evaluation of the entire claims process.

We believe SSA's quality assurance system will never meet its intended objectives until the uncorrected weaknesses we previously reported and those we have identified in this report are corrected.

Incomplete implementation of the quality assurance system

States

Each State agency is required to establish a quality assurance unit. This unit is responsible for improving State agency operations by reviewing a sample of the disability claims it processes, analyzing the results of that review, and conducting special studies.

In August 1976 we reported that the State agencies had placed varying degrees of emphasis on quality assurance activities. Most State agencies did not or were not able to comply with SSA quality assurance requirements. For example, 8 of the 10 States we reviewed said they lacked enough staff resources to comply. One State conducted its quality assurance activities on a part-time basis.

In several instances, other States we reviewed did not review the proper number of sample cases processed or furnish the proper number of sample cases to SSA regional and central

offices for their review. Also, several of these States discontinued or drastically reduced their quality assurance activities when pressed to expedite large backlogs of pending claims.

Our review indicated that the quality assurance system was still not properly implemented and functioning in the State agencies. For example, three of the seven States we reviewed said they lacked enough quality assurance staff to comply with SSA requirements. Three States did not review the proper size and mix of sample cases; two other States just started doing so in March 1977. One State agency selected an appropriate sample each day but did not always review all of it. Another State agency, in times of heavy workloads, relieved the quality assurance staff of their review function and used them to process claims.

The State agencies also varied in the extent to which they performed analyses of review results and special studies of agency operations. These functions are supposed to identify agencywide trends and provide recommendations for training and other corrective actions. Only two of the seven State agencies we visited performed regular analyses of State agency and SSA review results. These analyses were of limited value because they lacked enough data upon which corrective action could be taken. Likewise, only two State agencies performed special studies, as envisioned by SSA. Many State agency officials said they lacked sufficient staff to perform the trend analyses and special studies. In some cases, officials said their staff needed additional training to perform these functions.

Other variances among State agencies included the degree to which they have implemented supervisory reviews and physician participation in quality assurance review. The supervisory review is supposed to identify case processing problems and individual and unit training needs, and to assist other levels of management in identifying agencywide trends. Five of the seven States reviewed did not perform supervisory reviews which meet SSA requirements. Physician participation in the quality assurance review is supposed to evaluate the State agency's performance in medical evaluations and decisions. Four State agencies did not have a physician review which met these objectives. One of the three State agencies whose reviews are in compliance did not meet SSA's objectives until May 1977.

SSA regional and central offices

SSA's regional offices have two groups which are primarily responsible for the quality assurance system. The Case Review Section (CRS) is responsible for reviewing a sample of the title XVI and concurrent title II claims as a part of the second-tier review. The Analysis and Evaluation Unit (A&E) is responsible for analyzing the results of the CRS case review, developing trends, and conducting special studies at the regional or State agency levels.

We found that there were no guidelines for determining the number of positions required in each of these groups at any given regional office. Accordingly, their size varied widely among regions and some may be understaffed.

Most of the regions told us that they did not have enough medical consultants on their staffs to do the required 100-percent medical review of all sample cases. An official from one region told us that the CRS returns cases unreviewed because of the lack of manpower. CRS staff members in that region are also detailed to do other duties because of the shortage of personnel. Four of the six regions told us that their A&E units could not perform the necessary analysis and special studies required because of a lack of personnel.

We were also told that there were no standards for performance for these groups, and that there was a need for uniform training of CRS examiners and A&E staff to assure consistency throughout the regions.

The SSA central office is responsible for reviewing a sample of the title II claims as a part of the second-tier review. In addition, it reviews a sample of title XVI claims that have been reviewed by the CRSs in the regional offices. This latter review is now considered to be SSA's third-tier review. However, as discussed on page 17, when SSA officials originally explained their new quality assurance system to the Congress--it was intended that the third-tier function would provide an umbrella effect over the entire system and generate comparative data on a local and regional basis and national data to identify trends and problem areas. This would provide the information needed by management to take corrective action where necessary and help assure--to the extent possible--efficiency of program operation and uniformity of decisions. The SSA quality assurance system has never achieved this goal.

Central office officials said the need for adequate staffing shifted the thrust of its quality assurance emphasis. The third tier was never fully implemented as originally intended. Further compromising the integrity of the quality assurance activities, on February 22, 1978, SSA officials, in hearings of the Subcommittee on Social Security, House Committee on Ways and Means, conceded that an overall 5-percent sample review had never been achieved at central office.

SSA requested 128 additional staff years for its second-tier and third-tier qualify review functions in its fiscal year 1978 budget. However, the Office of Management and Budget (OMB) held the staffing for these functions at the 1977 level. OMB showed concern that these quality assurance activities did not identify errors in the process. Rather, SSA used them principally to correct individual cases reviewed instead of preventing future errors. OMB noted that if the disability insurance quality assurance system is not used to identify and correct errors in the process, the manpower for these activities may be cut in the next year's budget cycle.

We emphasized this shortcoming in the quality assurance system in our 1976 report. While we believe it is important that a proper sample be reviewed at each level within the SSA quality assurance system, it is equally important to identify and correct the source of the problems.

We share OMB's concern that the source of the problems still exists but we do not agree that staffing levels of SSA's second and third tier reviews should be reduced. We believe it is imperative that SSA direct priority effort toward identifying and correcting the source of errors in the process. To this end, SSA should be given the staffing necessary to review a proper sample and achieve the appropriate remedial action.

Inadequate feedback

In our August 1976 report, we concluded that feedback in the three-tier quality assurance system was inadequate and, as a result, it failed to assure reasonably uniform application of disability standards. Although SSA has made some recent efforts to improve the value of quality assurance feedback, more needs to be done.

Officials from all seven State agencies and five of the six regional offices we visited, told us the quality assurance system was not meeting its objectives. One SSA region

official described the system as a "farce" because it is merely a collection of statistics with which no one does anything. A State agency director agreed with this.

The inadequacy of the quality assurance system is magnified by the fact that it has been in operation for over 3 years, yet problems with medical criteria and guidelines and procedures still persist.

SSA and State agency officials agreed that most individual cases returned adequately identified deficiencies and the actions needed to correct them. These officials also agreed that this type of feedback is better under SSA's new guidelines for returning a broader range of cases with deficiencies. However, most State agency and SSA regional office officials agreed that feedback via periodic reports, trend analyses, and special studies at all levels has not been adequate. It was described as being too general, untimely, or not comparable between levels.

Individual claims are sometimes returned long after they were adjudicated by the State agency--in one case, 2-1/2 years later. Reports were delayed so long (often 5 to 6 months) that they were considered "ancient history" by State agency officials. Most State agencies we visited merely tabulated the deficiencies found in the quality reviews at the three levels. Little or no analysis was performed at any level to identify State, regional, or nationwide trends or problems.

In our opinion the most important level for conducting analysis and special studies of nationwide trends and problems is the SSA central office. This level is the only one that can take corrective action on policy and criteria matters which will have an impact on the entire system.

Central office officials said that the analysis and special studies, started as a result of their review, were limited in number because of the limited resources available. For example, there is only one full-time statistician performing statistical computations and statistical analyses of the disability program's quality assurance data at the central office. This statistician is assisted by a part-time statistician and by college students who have mathematics backgrounds.

Without adequate feedback within and between the three review levels, the quality assurance system cannot assure uniform, quality disability determinations. In order to achieve this goal, we believe sufficient adequately trained staff must be provided for the quality assurance functions at all levels.

Inconsistent application of SSA guidelines and criteria

SSA provides the guidelines and criteria to the States to document disability claims. These guidelines and criteria are not, however, applied uniformly by the State agencies and the SSA regional and central offices in conducting their quality assurance reviews. As a result, what constitutes an error in one place may not be considered an error at another location.

SSA regional and central office officials agreed that the State agencies and SSA apply these criteria differently.

State agencies follow what they describe as a "practical" or "reasonable" approach to documenting cases and obtain only enough medical evidence to allow a "reasonable man" to make a disability determination. The interpretation of what is practical or reasonable is determined by State agency policy or practice. Accordingly, the State agency quality assurance units review cases based on what they individually interpret to be practical or reasonable.

SSA central office, on the other hand, conducts its quality assurance review "by the book" and cites errors or deficiencies for anything less than ideal documentation. The SSA regional offices conduct their reviews on a basis somewhere between those of the State agencies and the SSA central office.

The difference between the ideal and practical concepts of documentation is a matter of degree. For example, using the ideal approach, SSA regional and central offices often require that case folders contain actual operative reports and/or laboratory test results, such as electrocardiogram tracings. Under the practical approach used by most State agencies, a doctor's description and interpretation of the operative reports or laboratory test results would be acceptable, especially in cases where other evidence supports the decision.

Most State agency officials said that their agencies are more inclined to follow the practical, more lenient approach because they are closer to the pressures and realities--of time and cost--of case processing than are the SSA regional and central offices. The State agencies are not likely, for example, to slow down case processing by recontacting a physician to request an electrocardiogram tracing when they already have the physician's interpretation of the report. Likewise,

they are not likely to incur additional costs by ordering an examination to describe a claimant's range of motion in degrees when they already have a physician's report saying it is very limited.

State agency officials pointed out that although SSA is concerned with the quality of determinations, it is also concerned with the time and cost of making them. Many State agency officials said that SSA's documentation requirements were not reasonable in light of its time goals for case processing. In addition, they said that SSA's primary emphasis was clearly on production time and cost. This has resulted in State agencies and individual case examiners adopting time and cost cutting practices, i.e., the practical approach to case documentation. One State agency uses a special task force to clear backlog cases. The task force clears all cases on which they believe a reasonable decision can be made based on evidence in the file at the time, regardless of SSA's criteria.

Some State agency officials complained that SSA often alternates its emphasis among cost, quality, and timeliness of decisions. This practice causes the States to doubt SSA's commitment to quality and encourages documentation shortcuts.

Other agency officials suggested that differences between their and SSA's approach to case documentation are also caused in part by inadequate medical criteria. These officials believe that SSA tries to enforce strict adherence to criteria which are outdated, vague, and unreasonable.

In addition to the inconsistent application of SSA guidelines and criteria between the various levels involved in the quality assurance system, the States use a data collection form that categorizes errors differently than the form used by the SSA regional and central offices. The regional offices also differed in the way they analyzed and reported the results of their reviews back to the States. Therefore, it is impossible to compare statistical data regarding deficiency rates found in the State agency quality assurance reviews to those found in the SSA regional and central offices reviews. We believe these problems will have to be corrected before the data being generated by the quality assurance system will become meaningful and beneficial in identifying needed changes.

SSA efforts to improve quality assurance

Since our August 1976 report, SSA has committed substantial resources for implementing an acceptable quality assurance system. Actions taken by SSA included:

--Issuing a comprehensive message to regional offices on strengthening State agencies' quality assurance activities and functions.

--Establishing standards for use in measuring timeliness and accuracy of State agency decisions.

--Further refinement of the standardized classification system for defining errors and/or deficiencies.

--Redesigning reports to provide users with more definitive data.

--Adding additional categories of deficiencies that are returned to the State agencies for further consideration.

--Implementation of a nationwide automated quality assurance data collection system.

--Work on an automated system for selecting sample cases for quality assurance review.

State agency and regional office officials said that these new actions should help to improve quality and provide better feedback throughout the system. However, they said this would not correct all the problems with the present system and that it was too early to tell if quality has been improved.

NEED FOR MORE PARTICIPATION BY MEDICAL CONSULTANTS IN DETERMINING DISABILITY

The agreements between the Secretary of HEW and the State agencies provide that the determination of disability shall be made by a medical consultant and other individual qualified to interpret and evaluate medical reports relating to physical or mental impairments. However, time, ever-changing procedures and instructions, and somewhat passive central management by SSA have joined to defeat this provision.

Physician participation in the disability decisionmaking process varied greatly among State agencies and among physicians within the same State agency. Decisions on the need for additional medical information, interpretations of that data, and the determination of a claimant's disability are, in many cases, made by claims examiners who, while possessing medical training in the disability field, do not have the formal medical training and knowledge of graduate physicians. Physicians' input into the decisionmaking process in some of the States we visited is merely a signature on the case before it "goes out the door."

For example, in some State agencies, physicians evaluate medical evidence collected by the claims examiners, authorize any requests for additional medical examinations or tests, and evaluate the significance of the claimants' impairments. In others, physicians do not normally participate in, nor are they consulted on purely medical matters until the lay claims examiner has authorized whatever consulting examination he deems necessary, analyzes its results, and renders a decision. Only then is the claim submitted for the physician's review. Thus, it is not surprising that some State agency officials indicated that the physician review in their States amounted to no more than a "rubber stamp" approval of the claims examiners' decisions.

One State agency has independently developed a pilot program which is an alternative approach to making disability evaluations. This program emphasizes more input into the decisionmaking process by medical consultants and is based on the premise that a proper initial decision will reduce errors, processing time, and the number of cases which go through the reconsideration and appeals processes. We believe this approach has merit.

The number of claims that are appealed nationwide, both at the State agency and the Administrative Law Judge levels, leads us to believe that a better job could be done in reaching the original disability decision. If that decision is made on adequate medical information, by individuals possessing the proper medical expertise, it would appear that claimants would receive more equitable treatment and the administrative burden associated with the current number of appeals could be reduced.

In addition, we believe that many of the current problems with the medical criteria could be eliminated with more active input by the medical consultants employed to support the disability program.

CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Under the existing Federal/State arrangement, SSA cannot exercise adequate managerial control of the State agencies. This circumstance, together with SSA's failure to correct other weaknesses in the disability determination process, provides no assurance that a reasonable degree of uniformity and efficiency will be achieved in these ever-growing, very expensive programs.

SSA's efforts since our August 1976 recommendations to strengthen the present Federal/State agreements have met with little or no success. Many State officials are unwilling to relinquish prerogatives accorded the State under the present agreements, such as determining their own organizational makeup, workflow processes, and training programs.

We believe the present Federal/State relationship is an impediment to improving the administration of the programs because of the (1) unanswered questions about the effectiveness and efficiency in the Federal/State relationship that have existed for almost 20 years; (2) questionable need for the process to be closely alined with the State Vocational Rehabilitation activities; (3) inability of the principals to remedy contractual defects, such as clearly defining their responsibilities; and (4) need for SSA to have more effective management and control over the disability programs.

The Social Security Act, as amended, intended that applicants for disability benefits receive objective and uniform consideration of their claims, regardless of where they are filed.

The quality and uniformity of disability decisions continue to suffer because SSA has not fully corrected the weaknesses that we reported on in August 1976. SSA agreed with our recommendations and has been working to implement them but more work is needed. So far, SSA has not (1) provided timely, clear, and concise criteria and guidelines for the States to use in making disability decisions; (2) assured that uniform training was provided to State agency employees; and (3) assured that an effective quality assurance system is properly implemented. In addition, during our current review we found that SSA had not made sure there

was adequate participation of physicians in the disability determination process.

There is still no adequate mechanism to effectively compare and evaluate the uniformity of State agency disability determination decisions. We believe SSA needs this information to fully discharge its responsibilities. SSA needs to continue work on establishing a statistically acceptable mechanism to determine and evaluate the uniformity of disability determinations on a regional and national basis.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary of HEW develop, for consideration by the Congress, a plan for strengthening the disability determination process by bringing it under complete Federal management so that SSA can achieve the control needed to properly manage the disability programs.

We recommend also that the Secretary direct the Commissioner of Social Security to continue work on:

--Assuring that clear, concise criteria and guidelines are provided for use in making disability determinations.

--Providing uniform training for those making the disability determinations.

--Assuring that the quality assurance system is properly implemented.

--Assuring that there is adequate participation by physicians in the disability determination process.

APPENDIX I

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

WASHINGTON, D.C. 20515

SUBCOMMITTEE ON SOCIAL SECURITY

January 5, 1977

Honorable Elmer B. Staats
Comptroller General of the United States
General Accounting Office
441 G Street, N. W.
Washington, D. C. 20548

Dear Mr. Staats:

The Social Security Subcommittee greatly appreciates the assistance rendered it through your recent report entitled, "The Social Security Administration Should Provide More Management and Leadership in Determining Who is Eligible for Disability Benefits." One of the weaknesses discussed in that report dealt with the effectiveness of the quality assurance activities at the State Agency and Social Security Regional and Central Office levels. Your report stated:

"The quality assurance system is not fully effective because:

--The system is not properly established or functioning in all State agencies.

--The feedback from all levels within the system has been inadequate.

--The trend analysis and special studies intended to correct systemwide problems are nonexistent.

--The sample size being reviewed at all levels may not be adequate.

--SSA's criteria for returning cases to State agencies for review and reconsideration may be too restrictive."

APPENDIX I

In commenting on your report, the Department of Health, Education, and Welfare discussed several actions it plans to take to improve this situation. The Department states that your study did not adequately take into account the impact of legislative decisions--such as the requirement that the determinations of disability must be carried out by State agencies--on its ability to assure uniformity and efficiency in the administration of the disability insurance program.

The Subcommittee believes that the quality assurance system is the key to the integrity and accountability of the entire disability program, since it is supposed to (1) identify problems related to individual examiners, individual state agencies, and the entire disability determination system and (2) provide feedback to the proper levels so that corrective action can be taken. The ability of the present system to achieve the integrity and accountability necessary for a fiscally sound disability program was a major concern of the Subcommittee when we made our initial request. Needless to say, as a result of the findings discussed in your report, it still remains a crucial but unanswered question.

Accordingly, the Subcommittee would greatly appreciate the immediate allocation of resources to follow-up on the actions taken and in progress by Social Security to improve the present quality assurance system at all levels involved. Specifically, we would like your assessment of the efficacy of past and planned actions by Social Security to improve this system, and whether you believe the present federal-state arrangement lends itself to or is an impediment to bringing about necessary changes. Prior to undertaking your study, we would like you to meet with and reach agreement with the Subcommittee staff on the scope of your review.

With all best wishes, I remain

Sincerely,

James A. Burke

JAMES A. BURKE, Chairman
Social Security Subcommittee

JAB/ac

APPENDIX II

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-164031(4) April 18, 1978

The Honorable
The Secretary of Health, Education,
and Welfare

Dear Mr. Secretary:

This letter is to inform you of the results of our review on the Social Security Administration's (SSA's) activities related to assessing the continued medical eligibility of over 2 million disabled Supplemental Security Income (SSI) recipients. We selected two samples of SSI disabled recipients and asked SSA to evaluate the recipients' continued eligibility. One sample required an evaluation of the medical evidence supporting the disability determination of 402 recipients who were converted to the SSI program from State disability programs. The other sample required SSA to obtain and evaluate more recent medical evidence on 175 recipients.

Of the 402 converted recipients, SSA found that only 152, or 38 percent, had sufficient medical evidence in their files to support a disability decision. Furthermore, of the 152 cases, 36 cases, or 24 percent, were not disabled as defined by the appropriate State disability criteria. SSA found that of the 175 recipients for whom current medical evidence was obtained, about 10 percent were no longer disabled.

It is important to note that under present operating procedures, SSA would not have reviewed the continued medical eligibility of many of the recipients in our samples. We believe that there is a serious weakness in the administration of the disability aspects of the SSI program which allows medically ineligible recipients, such as those identified in our samples, to go undetected.

While we did not review the 2.6 million disabled beneficiaries receiving benefits under the Social Security Disability Insurance program, the procedures for monitoring this program are similar to those used for the SSI program. Therefore, payments to beneficiaries who are no longer disabled could also occur under the Disability Insurance program and go undetected.

HRD-78-97
(10503)

B-164031(4)

We believe that it is important for SSA to monitor and evaluate the continued medical eligibility of disabled recipients and to identify weaknesses in the medical aspects of its programs that need strengthening.

Details of our findings and recommendations are presented in the following sections.

THE DISABILITY DETERMINATION PROCESS

The SSI disabled population consists of (1) persons who were converted from State programs of assistance for the blind and permanently and totally disabled to the SSI program when it became effective January 1974 and (2) those persons who entered the program after that date. To be eligible for SSI benefits, converted recipients have to meet State disability definitions, and new applicants have to meet Federal disability definitions. 1/

A claimant can apply for disability benefits at any SSA district or branch office. The application is forwarded to a State agency where medical and other evidence necessary for evaluation is developed. By law, State agencies under contract with the Department of Health, Education, and Welfare (HEW) make disability determinations. A State team consisting of a physician and a professional adjudicator is to determine whether disability exists under SSA prescribed medical criteria and guidelines.

If an applicant is found to be disabled, the team recommends to SSA whether a future medical reexamination should be scheduled, and if so, the date. A reexamination is scheduled when a beneficiary's impairment is expected, after continuing for 12 months or more, to improve sufficiently for the person to engage in substantial gainful activity. The establishment of a reexamination date is called a "diary."

1/ Public Law 93-233, December 31, 1973, required that a disabled individual entered on the States' rolls after June 30, 1973, must meet Federal SSI eligibility criteria to be converted to the Federal rolls.

B-164031(4)

CONVERTED RECIPIENTS DO NOT MEET DISABILITY CRITERIA

We selected a sample of 402 converted recipients residing in 7 States and requested that SSA review and determine whether the evidence used by the States in making the disability determination was sufficient.

SSA found that only 152 of the 402 cases, or 38 percent, were supported by evidence sufficient to support a disability decision. Of the 152 cases, medical evidence showed that 36 recipients, or about 24 percent, were not disabled as defined by the appropriate State criteria. The following table shows SSA's case review results by State.

State	Total cases reviewed	Adequate documentation available for decision: Disabled	Adequate documentation available for decision: Not disabled	Additional documentation needed to render decision
Colorado	64	12	6	46
Maryland	57	6	1	50
Massachusetts	58	10	5	43
New Mexico	62	28	8	26
New York	55	13	7	35
Oregon	49	26	3	20
Washington	57	21	6	30
	402	116	36	250
	100%	29%	9%	62%

Concerning the 36 recipients found to be not disabled, SSA reviewers commented that the beneficiaries' impairments (1) were not of sufficient severity to preclude substantial gainful employment, (2) could be improved through medication to permit working, or (3) were not supported by the medical evidence. However, only 12 of the 36 cases had been covered by a medical diary for a medical reexamination.

NONDISABLED PERSONS RECEIVE DISABILITY PAYMENTS

We also selected a sample of 175 disabled SSI recipients residing in 8 States and the District of Columbia, and had them readjudicated by the appropriate State agency. SSA reviewed and agreed with the State agencies' disability deter-

minations. The cases were adjudicated based on current medical evidence except for those which were not reexamined because the recipients' SSI casefiles showed that the recipients had severe medical impairments, were aged (65 years old), or had recently been determined disabled. See enclosure I for the criteria used to determine if current medical evidence did not have to be obtained.

About 10 percent, or 17 of the 175 sample cases (as shown in the following table) were found to be not disabled. Nine of the 17 failed to meet the Federal criteria, and 8 were converted cases that failed to meet the State criteria.

	Total cases reviewed	Disabled	Not disabled
California	36	33	3
Delaware	2	2	-
District of Columbia	15	15	-
Maryland	20	20	-
Nevada	7	6	1
New Jersey	24	22	2
Oregon	6	6	-
Pennsylvania	10	8	2
Washington	55	46	9
	175	158	17
	100%	90%	10%

None of the 17 cases found not disabled had been covered by a medical diary for a medical reexamination. Consequently, these recipients would not have been detected by SSA and removed from SSI rolls.

NEED FOR A SYSTEMATIC MEDICAL REVIEW OF THE DISABLED CASELOAD

SSA lacks an adequate system for reviewing its SSI disability caseload to insure that only medically eligible persons continue to receive disability payments. The decision on whether to review the continued disability of a recipient is based on guidelines for establishing a medical diary which have never been comprehensively reviewed. SSA estimates show that in 1976, 2.1 million disabled SSI recipients were paid $2.6 billion. However, only about 70,000

are scheduled annually for a medical reexamination. SSA is not monitoring or evaluating recipients not covered by a medical diary to determine whether recipients' impairments improve.

SSA has two quality assurance systems which deal, in part, with verifying recipients' eligibility status. However, neither system is structured to identify recipients not covered by a medical diary and whose impairments improve.

One quality assurance system which is operated by SSA's office of Quality Assurance concentrates on reviewing and verifying SSI recipients' income and resources. Payment errors identified in this review are reported to the Congress, HEW, and others, and serve as an indicator of SSA's management of the SSI program. However, the medical aspects of disabled SSI recipients are not reviewed or reported. Our samples showed that many recipients are not disabled. Therefore, the SSI payment error amounts reported by SSA may be significantly understated.

SSA's other quality assurance system is operated jointly by its Bureau of Disability Insurance and the State agencies to insure uniform application of disability standards nationwide. This system covers initial disability determinations, reconsiderations of previously denied applicants, and SSI and Disability Insurance cases having a medical diary but not recipients who are not covered by a medical diary. This quality assurance system concentrates primarily on evaluating whether the disbility criteria are applied correctly. However, it does not evaluate the adequacy of the guidelines for establishing medical diaries or if the guidelines are achieving their intended purpose--identifying those recipients whose impairments improve.

In our opinion, ineligible persons will continue to receive disability payments because SSA lacks an appropriate mechanism for systematically monitoring the disabled caseload so that persons who are no longer disabled can be removed from the rolls.

Subsequent to our discussions with SSA officials on the problems noted in this review, they informed us that SSA had recently begun two studies to medically review claims not normally scheduled for medical reexamination. The first deals with SSI conversion cases and the second with Disability Insurance cases in payment status for 15 years or longer.

The officials told us that if warranted by the studies, SSA may initiate a nationwide study of all disability cases without a medical diary to assess the adequacy of guidelines for establishing diaries.

CONCLUSIONS AND RECOMMENDATIONS

The vast majority of SSI disabled recipients, once they are approved for the program, are not subject to medical reexaminations. SSA assumes that these recipients have impairments which will not improve. The results of our samples indicate that many recipients were no longer disabled or were not disabled at the time they entered the SSI program. Payments to beneficiaries who are no longer disabled could also occur under the Disability Insurance program and go undetected.

We believe that it is important for the integrity of these programs to have quality assurance efforts which provide for (1) systematically reviewing the disability caseload so that ineligible persons can be removed from the disability rolls and (2) periodically reassessing the adequacy of guidelines for establishing medical diaries. Also the SSI quality assurance system should review and report on the medical aspects of disabled recipients as part of its overview of SSA's management of the SSI program.

Accordingly, we recommend that you direct the Commissioner of SSA to act immediately to establish appropriate mechanisms for systematically reviewing the disabled recipients' caseload so that persons no longer disabled can be removed from the rolls. In this regard Social Security should:

--Establish and implement systems for (1) periodically reassessing the adequacy of guidelines for establishing medical diaries for the total disability caseload and (2) reviewing, on a priority basis, the disability determinations for converted recipients. The studies being conducted by SSA in these two areas should be concluded as soon as possible and the results evaluated in terms of identifying and making needed improvements.

--Incorporate, in the present SSI quality assurance system operated by the Office of Quality Assurance, a mechanism for (1) reviewing the medical aspects of

APPENDIX II

B-164031(4)

disabled recipients in the SSI program and (2) reflecting the results of these reviews in Social Security's report to the Congress and to others. In addition a similar mechanism in the Office of Quality Assurance should be established for assessing and reporting on the Disability Insurance program administered by the Bureau of Disability Insurance.

- - - -

As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this letter to the Chairmen of the House Committee on Government Operations; Senate Committee on Governmental Affairs; House Committee on Appropriations; Subcommittee on Labor, Health, Education, and Welfare, Senate Committee on Appropriations; House Committee on Ways and Means; and the Senate Finance Committee. We are also sending copies of this letter to the Director, Office of Management and Budget. We appreciate the cooperation and assistance given by SSA personnel during our review, and we would appreciate being advised of any actions taken or planned on the matters discussed in this letter.

Sincerely yours,

Gregory J. Ahart
Director

Enclosure

APPENDIX II

ENCLOSURE I

ENCLOSURE I

LISTING OF CASE CHARACTERISTICS WHERE MEDICAL REEXAMINATION WAS NOT PERFORMED

1. Beneficiary will obtain age 65 before June 1977.
2. Amputation of two limbs.
3. Amputation of a leg at the hip.
4. Total deafness.
5. Statutory blindness.
6. Bed confinement or immobility without a wheelchair, walker, or crutches, due to a longstanding condition.
7. Cerebral palsy, muscular dystrophy, or muscular atrophy and marked difficulty in walking, speaking, or coordination of the hands or arms.
8. Diabetes with amputation of a foot.
9. Down's Syndrome (Monogolism or established IQ of 49 or less.)
10. Severe mental deficiency, at least 7 years of age, and requires care and supervision of routine daily activities.
11. Cases having a medical reexamination after July 1, 1976.

APPENDIX III

PRINCIPAL OFFICIALS OF HEW RESPONSIBLE FOR ADMINISTERING ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Joseph Califano	Jan. 1977	Present
David Mathews	Aug. 1975	Jan. 1977
Caspar W. Weinberger	Feb. 1973	Aug. 1975
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
COMMISSIONER OF SOCIAL SECURITY:		
Donald I. Wortman (acting)	Dec. 1977	Present
James B. Cardwell	Sept. 1973	Dec. 1977
Arthur E. Hess (acting)	Mar. 1973	Sept. 1973
Robert M. Ball	Apr. 1962	Mar. 1973

(105022)