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Report to the Committee on Ways and Means, Subcommittee on Social Security, House of Representatives

November 2021

SOCIAL SECURITY ADMINISTRATION

Actions Needed by SSA to Ensure Disability Medical Consultants Are Properly Screened and Trained

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GAO-22-103815

GAO Highlights

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Actions Needed by SSA to Ensure Disability Medical Consultants Are Properly Screened and Trained

November 2021

Highlights of GAO-22-103815, a report to the Committee on Ways and Means, Subcommittee on Social Security, House of Representatives.

Why This Matters

Social Security disability benefits are generally intended to help people who cannot work due to a disability. All of the state agencies that review disability claims consult with physicians to evaluate claimants' medical eligibility.

Concerns have been raised about:

1. SSA's oversight of states' consultants, and
2. Whether paying contract consultants per claim affects the quality of their work.

Key Takeaways

SSA cannot be sure that the state agencies' consultants are qualified and trained to appropriately inform decisions on disability claims.

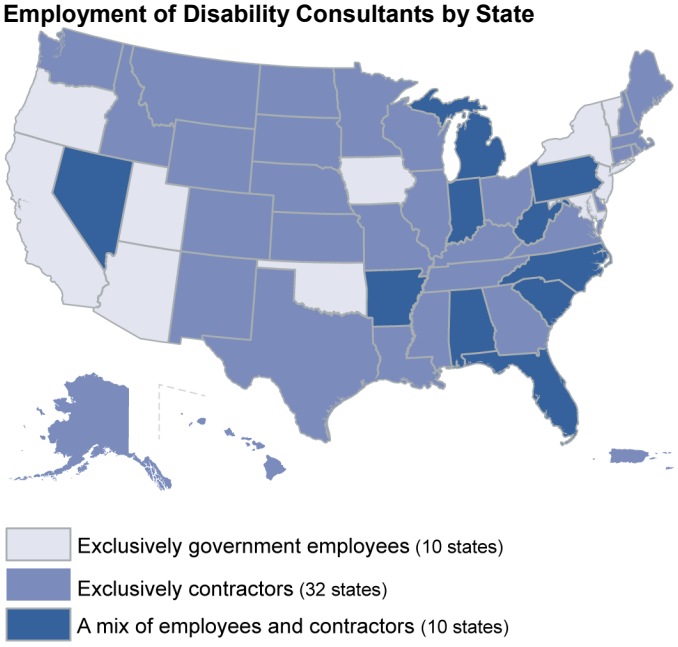
SSA policy requires state agencies to screen their consultants by checking them against a database of individuals barred from participating in federal programs. Also, SSA policy sets requirements for state agencies to provide initial and follow-up training. However, state agencies told us they do not always do so.

Of the 52 agencies:

- 14 said they did not consistently perform required checks on consultants either when hiring or annually, and
- Nine said they did not give consultants some element of required initial or refresher training.

We also looked into whether paying consultants per claim rather than an hourly or salary rate—which 19 agencies do—affects the quality of their work. Our analysis of SSA data did not find conclusive evidence of a link between how a state pays consultants and the quality of disability decisions in each state.

Employment of Disability Consultants by State



Source: GAO survey of state Disability Determination Services Administrators; National Atlas of the United States (base map). | GAO-22-103815

How GAO Did This Study

We surveyed disability agencies that review claims in the 50 states, District of Columbia, and Puerto Rico. We also analyzed SSA quality assurance data by state, reviewed SSA policies and relevant federal laws and regulations, and interviewed SSA officials and officials from agencies in several states.

What GAO Recommends

SSA should take additional steps to ensure states conduct required screenings and training, such as by clarifying its policies and providing periodic reminders. SSA agreed with our recommendations.

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Abbreviations

DDS	Disability Determination Services
DI	Disability Insurance
HRSA	Health Resources and Services Administration
LEIE	List of Excluded Individuals/Entities
NPDB	National Practitioner Data Bank
POMS	Program Operations Manual System
QA	quality assurance
SAM	System for Award Management
SSA	Social Security Administration
SSI	Supplemental Security Income

441 G St. N.W.
Washington, DC 20548

November 9, 2021

The Honorable John B. Larson
Chairman
The Honorable Tom Reed
Ranking Member
Subcommittee on Social Security
Committee on Ways and Means
House of Representatives

The Social Security Administration (SSA) provides cash benefits to certain individuals who are unable to work because of a disability—paying approximately $194 billion to 12.3 million individuals in 2019.[1] To determine whether individuals are eligible for disability benefits, the agency must consider a claimant's medical conditions and ability to work. Determinations of eligibility for disability benefits are made by Disability Determination Services (DDS) offices, which are operated by state agencies and funded by SSA. DDSs employ physicians, and psychologists or psychiatrists—known as medical consultants or psychological consultants, respectively—to review medical documentation collected as part of the disability application to assess whether claimants meet the medical criteria necessary to qualify for benefits. These consultants review medical evidence and work with DDS claims examiners to make the initial determination.

You expressed concerns about SSA's oversight of consultants following a media account in one state that reported contracted consultants paid per completed case may be motivated to complete their work quickly at the expense of quality.[2] In light of this and the negative effects that incorrect disability decisions can have on individuals, you asked us to study the use and oversight of consultants in SSA's disability determination process. This report examines (1) the extent to which state DDS offices use contracted consultants to review disability applications and how payment structures vary across DDSs; (2) the extent to which differences in consultant compensation structures are associated with differences in the accuracy of disability determinations; and (3) how and to what extent

[1]SSA paid $194 billion in disability benefits in fiscal year 2019. The number of beneficiaries (12.3 million) represents those receiving benefits in December 2019.

[2]Throughout this report, we refer to medical and psychological consultants collectively as "consultants."

DDSs report overseeing consultant performance, including establishing performance standards, and ensuring consultants are properly screened and receive required training.

To address the first objective, we conducted a survey of the 52 DDS administrators.[3] We visited one DDS prior to developing our survey in order to provide context for the questions we would ask. At the DDS, we interviewed officials to discuss how the DDS recruits and trains consultants, and oversees their work. We administered our survey between July and September 2020, achieving a response rate of 100 percent. Our survey collected information on the number and types of consultants working in each DDS and their compensation structures.

To determine whether there is an association between consultant compensation structures and accuracy of work (our second objective), we obtained data on SSA's quality assurance reviews for fiscal years 2017, 2018, and 2019.[4] These data included information on the number of DDS decisions reviewed by SSA's quality assurance program in those years for each state DDS, and the numbers and types of errors (known as deficiencies) identified in each state. Because SSA quality reviews do not attribute errors to consultants or other individuals, we analyzed SSA data to test whether a potential relationship exists between the rate of medically-related deficiencies per state and data from our survey on whether the state used employees or contractors, or whether the state used a compensation structure that could incentivize consultants to complete cases faster (such as paying consultants per case completed). We used statistical regressions to test for these associations. We determined that the quality assurance data we obtained are sufficiently reliable for the purposes of analyzing differences in deficiency rates among DDSs by interviewing knowledgeable officials and conducting electronic data testing.

To address our third objective, we reviewed relevant federal laws and regulations, and SSA policies to understand consultant requirements and the oversight that DDSs and SSA are required to provide. We also collected information through our survey on how DDSs oversee the quality of consultants' work, how DDSs ensure that consultants are licensed and eligible to serve, and on the training DDSs require for their consultants. We also interviewed officials from five DDSs, selected to

[3]We surveyed the 50 states plus the District of Columbia and Puerto Rico.

[4]The data from these years were the most recent data available at the time of our review.

provide some variety based on how they compensate their consultants (e.g., per hour or per case), whether they use employees or contractors, and potential issues we identified in our survey with how they carry out SSA policy requirements (such as checking the eligibility of consultants).[5] In addition, we interviewed officials from SSA to clarify what role the agency plays in overseeing DDSs' management of consultants and DDSs' quality assurance responsibilities.

To further address the third objective, we collected and reviewed documentation of consultant requirements—such as contracts or employee manuals—from nine states.[6] We chose these states for variety in DDS workloads (low, medium, and high), geographical location, and whether the states used contractors or government employees as their consultants. To provide insight into how DDSs check that consultants are appropriately licensed and meet SSA requirements to be employed, we selected a different sample of nine states—using the same criteria as above—and matched rosters of their consultants against several databases.[7] Specifically, we collected name and identifying information of all consultants who were employed as of August 1, 2020, and matched this information against the following three databases:

1. The System for Award Management (SAM). SAM contains information on whether individuals are excluded, suspended, or barred from participation in federal or federally-assisted programs.
2. The List of Excluded Individuals/Entities (LEIE). The LEIE is maintained by the Department of Health and Human Services Office of Inspector General, and lists individuals who are excluded from employment in federal health care programs for a number of reasons, including health care fraud. LEIE data also generally feeds into SAM.
3. The National Practitioner Data Bank (NPDB). NPDB contains information on adverse actions against medical providers, such as whether their medical licenses have been suspended or revoked. We used NPDB to match consultants from nine of 52 DDSs to determine

[5]We interviewed officials from California, Illinois, North Dakota, Rhode Island, and West Virginia.

[6]We reviewed documentation from Georgia, Idaho, Louisiana, Michigan, Missouri, New Jersey, North Dakota, Pennsylvania, and Rhode Island.

[7]We matched rosters of consultants from California, the District of Columbia, Kansas, Kentucky, Maine, Montana, New York, Texas, and Wisconsin.

if those consultants had suspended or revoked licenses counter to SSA policy.

We determined that these databases were sufficiently reliable for the purposes of screening consultants by reviewing available documentation and interviewing knowledgeable agency officials.[8]

Finally, for the third objective, we determined that two key principles of internal controls, as outlined in Standards for Internal Controls in the Federal Government, were significant in assessing SSA's oversight of DDS screening of consultants, and training provided to consultants. Specifically, these principles were: 1) management should design control activities to achieve objectives and respond to risks; and 2) management should implement control activities through policies.[9] See appendix I for additional information on our statistical analysis and other methodologies.

We conducted this performance audit from September 2019 to November 2021 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 our 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.

Background

SSA administers two main programs under the Social Security Act that provide benefits to individuals based on their disabilities—Disability Insurance (DI) and Supplemental Security Income (SSI). Individuals are generally considered to have a disability for the purposes of these programs if: (1) they cannot perform work that they did before and cannot adjust to other work because of their medical condition(s); and (2) their disability has lasted or is expected to last at least one year, or is expected to result in death.[10]

[8]We also consulted data reliability assessments performed as part of a contemporaneous GAO engagement using these databases.

[9]GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G, (Washington, D.C.: September 2014).

[10]42 U.S.C. §§ 423(d), 1382c(a).

An SSA field office[11] initially screens claims for disability benefits to determine if the claimant meets non-medical eligibility requirements.[12] If those eligibility requirements are met, the field office forwards the application to a DDS office to evaluate the claim against medical eligibility requirements and make the disability determination.[13] SSA funds the DDS offices, which are state-run agencies, to process disability claims in accordance with SSA policies and procedures.

According to SSA policy, the DDS assigns claims to a disability examiner, who is responsible for correctly developing the case needed to decide a claim and preparing the determination. To develop the case, the examiner obtains evidence from the claimant and medical providers, requests additional medical evidence if needed, and prepares the case for review by medical and/or psychological consultants, depending on the type of impairment claimed.[14] The consultant is responsible for evaluating the sufficiency of the medical evidence collected and whether there is a need for further medical testing, assessing the existence and severity of the claimant's impairments, and determining if the impairments meet the medical criteria. In addition to evaluating medical evidence for initial claims, consultants employed by DDSs also evaluate medical evidence used in reconsideration and continuing disability review cases using the same SSA standards.[15] Figure 1 summarizes the disability determination process.

[11]SSA operates approximately 1,200 field offices nationally that are located within ten regional offices. Among other things, staff at field offices receive disability claims, complete final processing and payments of claimants determined to be disabled, and process benefit denials and hold files for possible appeal from those denied benefits.

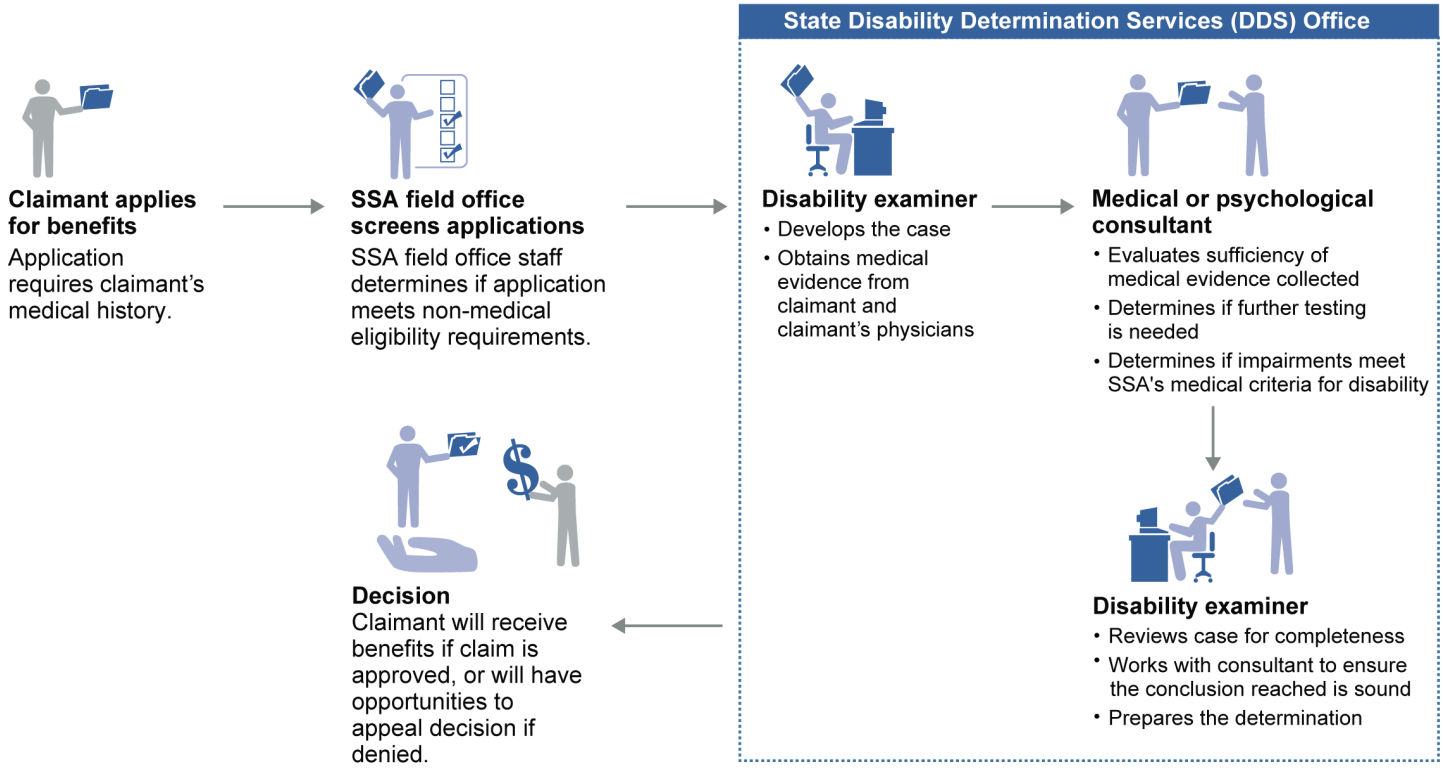
[12]Examples of non-medical requirements include determining if SSI applicants have assets and earnings below relevant limits, and if DI claimants have sufficient work history to be eligible.

[13]SSA uses the same disability determination process in both DI and SSI.

[14]The SSA disability process also includes an assessment of vocational factors, such as whether an applicant can perform prior work or any work in the national economy. This assessment is beyond the scope of this report.

[15]If a claim is denied, claimants can request a reconsideration. In a reconsideration, a different group of DDS staff examine previous and any new medical and vocational evidence to make a second disability determination. A continuing disability review is a periodic reevaluation of a case to determine if an existing disability beneficiary continues to meet the criteria for disability eligibility.

Figure 1: Role of the Medical or Psychological Consultant in the Initial Social Security Disability Determination Process



Source: GAO analysis of Social Security Administration (SSA) policies and procedures. | GAO-22-103815

Text of Figure 1: Role of the Medical or Psychological Consultant in the Initial Social Security Disability Determination Process

- Claimant applies for benefits. Application requires claimant's medical history.
- SSA field office. screens applications SSA field office staff determines if application meets non-medical eligibility requirements.
- State Disability Determination Services (DDS) Office.
  - Disability examiner.
    - Develops the case
    - Obtains medical evidence from claimant and claimant's physicians
  - Medical or psychological consultant.
    - Evaluates sufficiency of medical evidence collected

    - Determines if further testing is needed
    - Determines if impairments meet SSA's medical criteria for disability
  - Disability examiner.
    - Reviews case for completeness
    - Works with consultant to ensure the conclusion reached is sound
    - Prepares the determination
- Decision. Claimant will receive benefits if claim is approved, or will have opportunities to appeal decision if denied.

Note: Consultants also play a role in evaluating medical evidence when claimants disagree with SSA's initial decision and request reconsideration.

Source: GAO analysis of Social Security Administration (SSA) policies and procedures. | GAO-22-103815

Federal regulations and SSA policies lay out a number of requirements for DDSs regarding their use of consultants, including:

- **Licensure and credentials**. Medical consultants must be licensed physicians (e.g., a medical or osteopathic doctor), and psychological consultants must be either a licensed psychologist or psychiatrist.[16] Prior to using the services of a consultant, the DDS is required to verify consultant licenses, credentials, and certifications with state medical boards, psychology boards, and other state professional certification bodies. For existing consultants, DDSs must periodically verify that licenses remain active and are renewed prior to renewal dates. For both newly hired and existing consultants, the DDS must document that the verification occurred.[17]
- **Screening using SAM**. DDSs must ensure that consultants are not listed in the SAM database. Among other things, SAM contains information on medical providers that are currently excluded, suspended, or barred from participation in federal or federally-assisted programs. Per SSA policy, DDSs are required to check SAM and document the results before first employing a consultant, and then at least annually thereafter.[18]

[16]SSA Program Operations Manual System (POMS) DI 24501.001(C).

[17]POMS DI 39569.300(C)(2).

[18]POMS DI 39569.300(C)(2).

- **Training**. According to SSA policy, consultants should fully understand SSA disability claims documentation requirements so that they can assess the adequacy of medical evidence in relation to SSA regulations and adjudicative criteria. SSA policy also states that good initial and follow-up training are needed so that consultants and examiners function as a team.[19]

In addition, both regulation and SSA policy broadly require DDSs to have a quality assurance process in place to ensure that disability determinations are made accurately and promptly. According to SSA policy, the DDS quality assurance process should be designed to promote both the accuracy and timeliness of disability determinations. At the same time, SSA policy allows each DDS to decide how to structure its quality assurance function and the scope of related activities.

At the national level, SSA conducts its own reviews of cases decided by DDSs. These reviews are intended to determine whether claims are decided in accordance to SSA rules and that decisions are correctly documented. For its quality assurance reviews, SSA quarterly chooses a random sample of 70 favorable (benefits approved) and 70 unfavorable (benefits denied) initial determinations from each DDS. The results of these reviews count towards DDS performance accuracy thresholds, which by regulation is 90.6 percent.[20] SSA will intervene if a DDS fails to meet the performance standards for two consecutive quarters by taking remedial actions such as additional training for DDS staff and case reviews.[21] SSA also selects similar random samples of reconsideration and continuing disability review determinations from each state, but these samples do not count towards the DDSs' performance accuracy level.[22] Claims with mistakes (known as deficiencies) are returned to the states for corrective action along with information explaining the cause of the

[19]POMS DI 39563.450(C).

[20]The accuracy rate is for combined DI and SSI cases.

[21]In addition to performance accuracy, DDSs have processing time standards for DI cases and SSI cases. SSA will notify the DDS that it is not meeting standards if it misses two of three threshold levels—one of which must be performance accuracy.

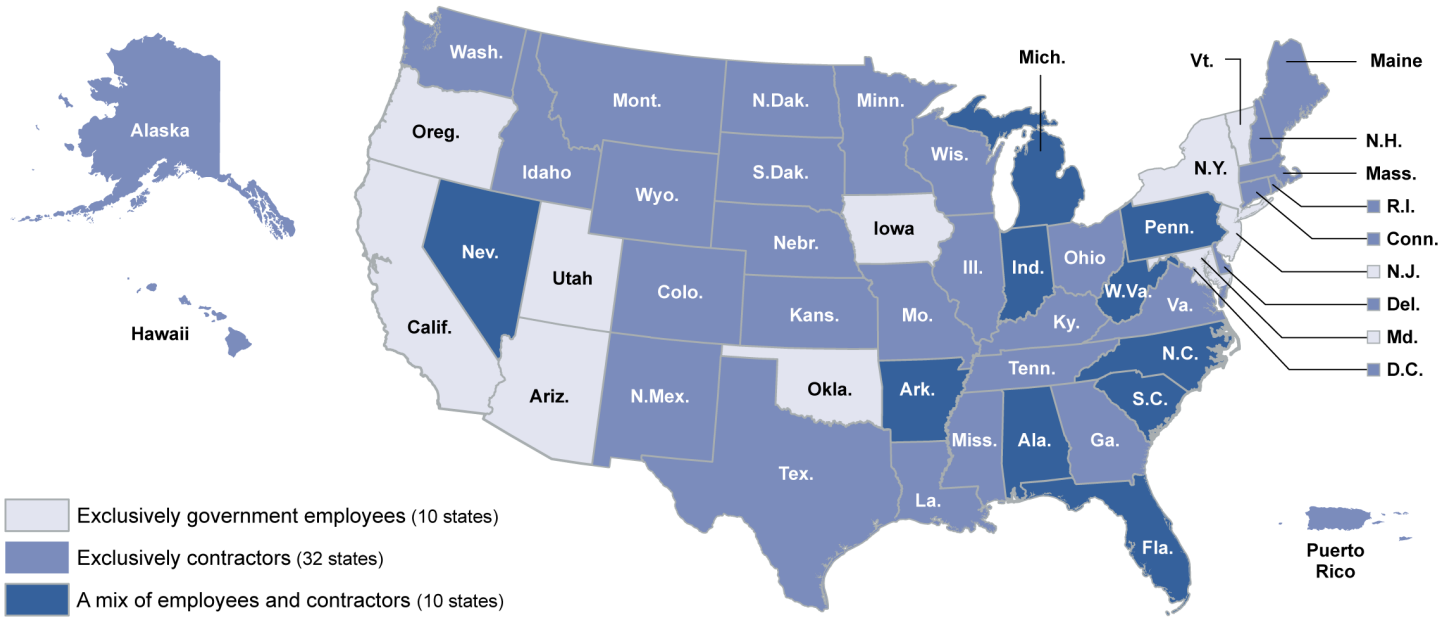
[22]In addition to these randomly sampled quality assurance reviews, SSA also conducts Pre-Effectuation Reviews (PER) and targeted denial reviews. For PER, SSA is required by law to review at least 50 percent of all favorable disability initial and reconsideration decisions. 42 U.S.C. §§ 421(c), 1383b(e). These cases are selected by a predictive model that focuses on problematic types of claims. These reviews do not count towards DDS performance accuracy scores. Targeted denial reviews are discretionary reviews in which SSA selects particular types of error-prone claims that have been denied. These reviews do not count towards DDS performance accuracy scores.

deficiencies. DDSs either make the correction identified by SSA or have the option to contest the deficiency with SSA.

Most State DDS Offices Use Contracted Consultants Who Are Compensated Either Hourly or Per the Claims They Review

A large majority of states use contracted consultants, according to our survey results. Of the 52 DDSs, 32 reported that, as of June 1, 2020, they exclusively use contracted consultants and another 10 use a combination of contractors and employees. Figure 2 depicts which DDSs use employees, contractors, or a mix of both.

Figure 2: Use of Employee and Contracted Medical, Psychological, and Other Consultants by Disability Determination Services Offices as of June 1, 2020[a]



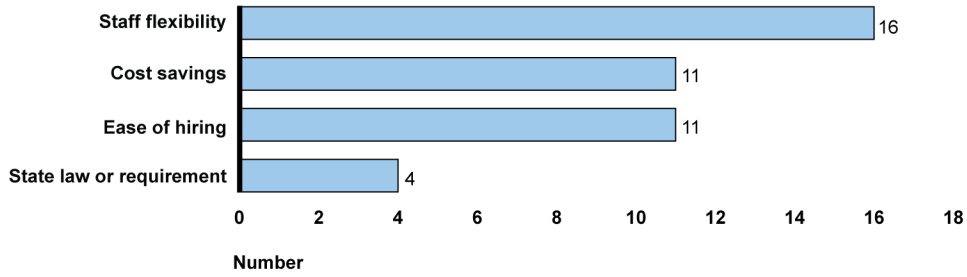
Source: GAO survey of state Disability Determination Services Administrators; National Atlas of the United States (base map). | GAO-22-103815

[a]Other consultants employed by DDSs to review medical evidence included speech-language pathologists and audiologists, among other specialties.

The reasons for which DDSs reported using contractors vary. Of the 32 states that exclusively use contractors, the most frequent answer given (by 16 DDSs) was that contractors afford DDSs staffing flexibility. For example, officials we interviewed at one DDS told us they would have

trouble retaining consultants if they were converted to employees because employees have less flexible schedules, adding that many of its consultants are retired physicians who like to work part-time or flexible schedules. Additionally, officials at this DDS said that they would be unable to pay consultants a competitive salary under the state's salary structure. Officials at another DDS told us that using contractors allows the DDS more flexibility to assign consultants cases according to the needs of the DDS and its workloads. Figure 3 below summarizes reasons DDSs reported for using contracted versus employee consultants. In contrast, six of the 10 DDSs that exclusively use employees reported that there is a state requirement to use government employees.

Figure 3: Reasons for Which Disability Determination Services (DDS) Reported Using Contractors (of the 32 DDSs that exclusively use contractors)



Source: GAO survey of state Disability Determination Services administrators. | GAO-22-103815

Note: The number of reasons do not total to 32 because DDSs were able to select multiple reasons.

All employee consultants are paid salaries or per hours worked, while contractor compensation is split between DDSs that pay per hour and those that pay according to how many cases or actions are completed. Specifically, of the 42 DDSs that use contractors—either exclusively (32) or in combination with employees (10)—23 reported paying consultants by the hour and 19 for each case or action completed.[23] In their survey comments, some DDSs reported differing reasons for their choices on how to compensate contracted consultants. For example, two DDSs reported that they pay contractors hourly in order to emphasize the quality of reviews over productivity. In contrast, another DDS noted that

[23]Eight DDSs reported that they pay contractors based on both the number of cases reviewed and an hourly rate. In each of these DDSs, they reported that they pay their consultants a flat rate for each case they review, but pay consultants an hourly rate for other duties they perform such as participating in training. We counted these DDSs as paying consultants per case.

productivity increased when it began paying contractors per case completed.

Our Analysis Did Not Show a Clear Relationship between Consultant Compensation Structures and Accuracy

To determine whether there is an association between DDS accuracy rates and their compensation structures or whether they use contractors or employees, we analyzed:

- state-level data for deficiencies identified through quality reviews conducted by SSA from fiscal years 2017-2019, including deficiencies potentially attributable to mistakes in reviewing medical evidence; and
- data from our survey on how states compensate consultants (e.g., per case reviewed), and whether states use contractors or employee consultants.

Our analysis of SSA quality assurance data did not show a statistically significant relationship between DDS accuracy involving medical evidence and how DDSs compensated consultants. Using statistical regressions, we found only small differences in medical deficiency rates among states according to compensation structures, and the differences were not statistically significant at the 95 percent confidence interval (see table 1). Given these results and limitations in the data available to us, there was not enough evidence to conclude that an association between DDS accuracy and compensation structures exists.[24] It is possible that addressing data limitations, such as controlling for additional factors, could produce a conclusive result. Appendix I provides additional information on our analysis of quality data and results.

[24]As we described earlier in the report, SSA quality reviews do not determine or track whether a deficiency is attributable to a mistake committed by a consultant. Therefore, we could not directly test whether consultants are more or less likely to have differences in the quality of their work based on how they are compensated. Since errors in reviewing medical evidence could be attributed to either consultants or the DDS disability examiners who may rely on consultant input, any differences found would only suggest that a relationship might exist between consultant compensation structures and errors.

Table 1: Estimate of Medical Deficiencies Rates (using SSA's random quality assurance sample for fiscal years 2017-2019) According to DDS Consultant Employment Type and Compensation Model

	DDS consultant employment type[a]			DDS consultant compensation model[a]	
	Employees exclusively	Contractors exclusively	Mix of employees and contractors	Paid per case or action	Paid per hour or salary
Mean rate of medical deficiencies	3.3%	3.5%	3.5%	3.7%	3.3%

Source: GAO analysis of Social Security Administration (SSA) random quality assurance sample for fiscal years 2017-2019, and GAO survey of state Disability Determination Services (DDS) agency administrators. | GAO-22-103815

Note: Medical deficiencies are errors identified in disability claim decisions that could be attributable to mistakes in reviewing medical evidence.

[a]We calculated deficiency rates as a percentage of all cases reviewed by SSA in fiscal years 2017-2019 through its random quality assurance sample. Differences in deficiency rates are not statistically different at the 95 percent confidence level.

All DDSs Reported Reviewing the Quality of Consultant Work, but Some DDSs Reported Not Conducting Eligibility Checks or Training Required by SSA Policy

All DDSs Reported Using Quality Reviews to Track Consultant Performance, but Their Expectations and Methods Vary

SSA generally relies on DDSs to oversee the performance of their consultants. According to agency officials, SSA's random quality reviews of sampled claims are its primary means of ensuring consultants perform quality work. While SSA policy assigns primary responsibility to its regional offices to directly oversee and monitor DDS performance, officials told us that SSA has no policy requiring its regional offices to directly oversee consultant performance, and the regional offices generally take proactive action only if a complaint is made against a DDS or if SSA identifies quality issues in claims decided by a DDS.[25] According

[25]SSA's 10 regional offices are responsible for the oversight and support of all Social Security programs in their respective field offices and state DDS offices.

to agency officials, the regional offices mostly serve as a resource for DDSs, such as helping them interpret SSA policy on consultants.

All DDSs reported having an internal quality assurance process, but they varied in the type of internal processes they implemented. SSA regulation requires DDSs to have an internal quality assurance (QA) process to broadly oversee quality, but allows each DDS to decide how to structure this function and scope of activities.

SSA policy states that an in-line (i.e., pre-decisional) quality review approach is needed to fully evaluate and maintain the quality of a DDS's product.[26] Of the 52 DDSs, all reported having an internal QA process that involved either pre- or post-decisional reviews of cases, or both:

- 13 reported conducting pre-decisional quality reviews;
- four reported conducting post-decisional quality reviews; and
- 35 reported conducting both.

In addition, SSA policy states that the objectives of a DDS QA system are to, among other things, provide a means for measuring performance of individuals and groups, which would include consultants.[27] All 52 DDSs reported also using data from their internal quality reviews to monitor the performance of their consultants.

DDS officials we interviewed from five states provided further insight into the methods they use to track or use information about the quality of consultants' performance. For example, three DDS officials (all from states that reported using pre-decisional reviews in our survey) said they track consultant errors identified in internal quality reviews or SSA QA returns, or take a sample of cases for review to identify possible quality issues. Officials from those same DDSs noted that if they identify quality issues, they follow up with those consultants to discuss any errors and corrections, and provide additional training or guidance. Officials from two DDSs (including one that reported not using pre-decisional reviews) said that it is easy to track their consultants' performance because their offices have a small number of consultants on staff such that DDS supervisors

[26]POMS DI 30001.001(A). Pre-decisional reviews are those conducted before a final decision is made.

[27]POMS DI 30001.005(A).

can identify trends in errors that they can attribute to an individual consultant.

DDSs also vary in the extent to which they establish accuracy standards for the case review work performed by consultants. SSA policy requires DDSs to meet accuracy standards for the cases they decide, but, according to SSA officials, defers to the DDSs to monitor the work performed by individual consultants. While 25 DDSs reported setting a minimum accuracy rate for consultants' case reviews as part of their performance standards, approximately one-half of DDSs (26 of 51) reported they did not.[28] In particular, about two-thirds of DDSs that exclusively use contracted consultants (22 of 32) reported not setting minimum accuracy rates for consultants, whereas only a few DDSs using government employee consultants—either exclusively (two of 10) or in combination with contractors (two of 10)—reported not setting minimum accuracy rates for consultants. DDS officials from one state we interviewed said they do not set minimum accuracy standards for consultants because it is difficult to attribute errors to individual consultants due to multiple consultants often working on a case. In contrast, one state said it collects monthly data on consultant accuracy, and another state said its QA staff provide feedback on the accuracy of cases they review.

Similarly, DDSs vary in the extent to which they establish productivity standards for consultant case reviews, which SSA officials said are not required by SSA policy. While 30 of 52 DDSs reported setting a minimum productivity rate at which consultants are expected to review cases, 22 reported they did not. Additionally, one DDS official we interviewed said that their DDS does not hold consultants to their minimum productivity expectation because they want consultants to focus on the quality of their reviews. Another DDS official we interviewed said that quality levels decline when consultants review more than six cases per hour, so DDS officials limit consultants to six cases per hour and intervene when consultants exceed that number.

[28]We excluded from the total one DDS that reported using a mix of employees and contractors and setting a minimum accuracy rate for its employee consultants, but not for its contracted consultants.

Some DDSs Reported Not Screening Consultants or Providing Some Training as Required by SSA Policy

Some DDSs reported not screening consultants as required by SSA policy. Specifically, DDSs are required to check whether consultants are listed in SAM when hiring a new consultant and then annually thereafter.[29] However, 14 of 52 DDSs we surveyed reported not consistently checking newly hired or existing consultants in SAM, of which six DDSs reported not checking SAM for either. Officials we interviewed from three DDSs gave different reasons for not checking SAM:

- Officials from one DDS with a new leadership team were unfamiliar with the SAM database or the requirement in SSA policy to check it until we discussed it with them.
- Officials from the second had not started checking SAM until the month of our meeting when reminded by their regional office to prepare for an audit.
- Officials from the third were aware of the SSA policy requirement but did not check SAM, believing that checking its state licensure database was more useful. However, a state licensure database would not include information on whether individuals are excluded or suspended from participating in federal programs.

SSA conducts some oversight over whether DDSs are screening consultants against SAM, but this oversight is limited and infrequent. According to SSA officials, as part of its broader audit of DDS administrative costs, an auditing firm contracted by SSA selects a sample of DDS consultants and reviews DDS documentation to determine whether the DDS checked their license and SAM status. Officials said the auditor looks for screenshots to prove that the DDS checked the state licensure and SAM databases, and for a record of the date and name of the employee conducting the check. SSA officials told us that its current plan, starting in 2021, is to audit each DDS once within a 5-year period. Because a sample of consultants will be reviewed from each DDS once

[29]As noted earlier, SAM contains information on whether individuals are excluded, suspended, or barred from participation in federal or federally-assisted programs.

every 5 years, it is possible for a consultant to be employed for a long period of time without SSA verifying that they are not listed in SAM.[30]

We searched SAM for the names of consultants employed by a sample of nine DDSs to determine whether DDSs might be employing consultants barred from participating in federal programs. We did not find any consultants from our sample of nine DDSs listed in SAM. We also searched for whether these consultants were listed in two other databases—one that also lists individuals barred from federal programs (LEIE), and one including physicians with suspended licenses (NPDB)—and did not find any of the consultants listed in those databases. However, because our analysis only included consultants staffed at nine of 52 DDSs, it is still possible that some DDSs employ consultants who are ineligible to work on SSA programs.

Federal internal control standards state that agency management should design control activities to achieve objectives and respond to risks, and that management should implement control activities through policies, such as through periodic reviews of control activities.[31] Given that about one-fourth of DDSs reported not following policy, despite audits reviewing a sample of consultants every 5 years, SSA may not have sufficient control activities in place to ensure that DDSs follow its policies regarding checking SAM. Without additional oversight to help ensure that its policies are followed, SSA runs the risk that some DDSs may employ consultants who are ineligible.

In addition to not conducting SAM checks, some DDSs reported not training consultants as required by SSA policy. SSA policy states that physicians should fully understand SSA disability claims documentation requirements so that physicians can assess the adequacy of medical evidence in relation to SSA regulations and adjudicative criteria. Additionally, SSA policy states that good initial and follow-up training are

[30]Additionally, a contracted auditor reviews a small sample of consultants as part of the SSA Office of Inspector General's (OIG) financial statement audit. According to SSA officials, the auditor selects a sample of 45 cases that have been through one of SSA's quality reviews. As part of its review of those cases, the auditor will verify that consultants who worked on these cases were properly licensed, but this audit does not systematically cycle through DDSs thereby ensuring that that all DDSs—and their consultants—are periodically audited.

[31]GAO-14-704G.

needed to ensure that the examiner and physician function as a team.[32] However, according to our survey, nine of 52 DDSs reported not providing some of the required training to their consultants. Specifically, one DDS reported not conducting training for newly-hired consultants, six reported not conducting refresher training for experienced consultants, and two reported conducting neither.

SSA officials said that while the agency provides DDSs with training materials, it does not review the quality of training provided to their consultants. In addition, according to SSA officials, audits of DDSs do not cover consultant training. Federal internal control standards state that agency management should design control activities to achieve objectives and respond to risks, and that management should implement control activities through policies, such as through periodic reviews of control activities.[33] Contrary to this, SSA does not have sufficient control activities in place to ensure that DDSs follow SSA policies on consultant training. In the absence of oversight of consultant training, the agency cannot ensure that consultants are properly trained in how to review disability claims, or that consultants receive remedial or refresher training when needed.

Conclusions

Consultants play an important role in SSA's disability determination process and are responsible for helping to evaluate medical evidence against criteria. SSA largely delegated responsibility for overseeing consultant performance to DDSs, and this delegation is reflected in the range of processes, methods, and standards used by DDSs to oversee performance. SSA policy prohibits DDSs from employing consultants who are barred from participating in federal programs. However, a number of DDSs reported not checking consultants against the SAM database as required by SSA policy, thereby risking employing consultants who are not eligible. Additionally, SSA has established requirements for consultant training, and it is incumbent upon SSA to sufficiently monitor DDSs' adherence to its rules. However, a number of DDSs reported not

[32]Further, SSA policy states that DDS training plans should identify and address in-service training needs resulting from new hires, staffing shifts, establishment of new positions; changes such as amendments, new programs and changes in policy, procedures, or systems; and performance improvement areas (advanced, refresher, or remedial training).

[33]GAO-14-704G.

providing some required training, and SSA does not know the extent to which consultants are receiving required training.

Recommendations for Executive Action

We are making the following two recommendations to SSA:

The Commissioner of the Social Security Administration should take additional steps to ensure DDSs conduct required SAM checks for consultants, such as policy reminders or periodic checks of compliance. (Recommendation 1)

The Commissioner of the Social Security Administration should take additional steps to ensure DDSs' compliance with SSA's training policy for consultants, such as reviewing the adequacy of training DDSs provide or sending DDSs periodic reminders about initial and follow-up training policies. (Recommendation 2)

Agency Comments and Evaluation

We provided a draft of this report to the Social Security Administration for review and comment. SSA agreed with our recommendations and its response is reproduced in appendix II.

We are sending copies of this report to the appropriate congressional committees, the Acting Commissioner of the Social Security Administration, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov

If you or your staff have any questions about this report, please contact me at (202) 512-7215 or curdae@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.

Elizabeth H. Curda, Director
Education, Workforce, and Income Security Issues

Appendix I: Objectives, Scope, and Methodology

This report examines the use and oversight of consultants in reviewing disability claims for the Social Security Administration (SSA). Specifically the report addresses: (1) the extent to which state disability determination services (DDS) offices use medical consultants to review disability applications and how payment structures vary across DDSs; (2) the extent to which differences in consultant compensation structures are associated with differences in the accuracy of disability determinations; and (3) how and to what extent DDSs report overseeing consultant performance, including establishing performance standards, and ensuring consultants are properly screened and receive required training.

To address the first and third objectives, we conducted a survey of all DDSs. For the third objective, we also matched consultants from nine states against several databases to gain insight into how DDSs check consultants' eligibility for employment. For our second objective, we conducted statistical analyses to test for statistical relationships between the accuracy of claims in each state, and the employment and compensation models in those states. This appendix provides additional detail on these key methodologies.

Survey of Disability Determination Services

We conducted a survey of all 52 DDS offices to obtain information on the extent to which DDSs use employee or contracted consultants, how they oversee consultant performance, and how they ensure consultants are properly licensed and not excluded from participation in federal programs.[1]

In developing the survey, we pretested drafts of the questionnaire with four DDSs to ensure that (1) the questions were clear and unambiguous, (2) terminology was used correctly, (3) the questionnaire did not place an undue burden on agency officials, (4) the information could feasibly be obtained, and (5) the survey was comprehensive and unbiased. We chose the four pretest participants to provide some variation according to

[1]The 52 DDSs include the 50 states, the District of Columbia, and Puerto Rico.

whether they used employee or contractor consultants, how consultants are compensated (e.g., hourly or pay-per-case), and DDS claims workloads. We further limited our selection to DDSs that were operating during the pandemic at the time of our pretests. We considered the feedback we received when pretesting our survey and incorporated revisions into our final survey as appropriate.

We administered our survey between July and September 2020. We received survey responses from all 52 DDSs. Subsequently, we followed up with a number of DDSs to clarify some responses, including instances where their survey responses were missing, their responses were contradictory or appeared erroneous, or their responses indicated that a DDS may not be carrying out an SSA policy. We updated DDSs' survey responses as appropriate.

Matching Consultants against Exclusions Databases

SSA policy requires that DDSs verify and document that consultants:

- have an active and current license, and
- do not appear on the System for Award Management (SAM), which, among other things, contains information on medical sources that are excluded, suspended, or barred from participation in federal or federally-assisted programs.

DDS are required to do these checks when consultants are hired, and then check licensure periodically and SAM annually thereafter.

To gain insight into how DDSs screen consultants, we matched rosters of consultants employed as of August 1, 2020, by nine states against several databases. We selected these states based on their claims workloads, geographical location, and whether the states used contractors or government employees as their consultants. Specifically, we obtained information from California; Kansas; Kentucky; Maine; Montana; New York; Texas; Washington, D.C.; and Wisconsin. Using identifying information for these consultants, we matched them against:

- **SAM**. We obtained an extract of exclusion records from the SAM database current as of January 2020. We found no matches using SAM.
- **The List of Excluded Individuals/Entities (LEIE)**. The LEIE, maintained by the Department of Health and Human Services (HHS)

Office of Inspector General, is a database that contains information on individuals and entities barred from participating in federal health care programs. We obtained an extract of the database current as of January 2021. We found no matches using this dataset.

- **The National Practitioner Data Bank (NPDB)**. NPDB, which is maintained by HHS's Health Resources and Services Administration (HRSA), is a repository for information on medical malpractice payments, license revocations, and other adverse actions related to health care practitioners.[2] We provided our list of consultants to HRSA to conduct the matching and HRSA provided us with a list of potential matches in December 2020. We did not identify matches indicating that consultants were employed in violation of SSA policy.[3]

We assessed the reliability of these databases by reviewing available documentation and interviewing knowledgeable agency officials. We also consulted data reliability assessments performed as part of a contemporaneous GAO engagement using these databases. We determined that all three databases were sufficiently reliable for the purposes of our screening consultants.

Analysis of Quality Assurance Data

We used statistical regression methods to analyze SSA's quality assurance data to determine if there was a potential relationship between DDSs' compensation structures for consultants and the accuracy of DDSs' disability determinations.

Data Sources

To determine the compensation structures used by DDSs, we surveyed state DDS administrators on whether they:

- use contracted consultants exclusively, employees exclusively, or a mix of the two; and

[2]According to HRSA officials, NPDB is a tool to enhance review of health care practitioners, and prevent health care fraud and abuse, with the ultimate goal of protecting the public.

[3]These potential matches did not include instances of license revocations, but did include instances of prior suspensions as well as lesser punishments such as censure or probation. According to SSA, its policies only require consultants to be currently licensed, and does not address prior suspensions or less serious actions.

- compensate consultants via salary, per hour, or per case or action completed.

For the purposes of our statistical analysis, we categorized compensation models according to whether they might incentivize consultants to review cases quickly. Specifically, we considered salaried or hourly pay to not incentivize speed, and considered models that pay by case or action completed to potentially incentivize speed.[4]

Regarding the accuracy of DDSs' disability determinations, we analyzed the results of SSA's quality assurance reviews of randomly sampled DDS determinations. These reviews consist of three random samples: a sample of DDS initial determinations, a sample of DDS reconsideration decisions, and a sample of continuing disability review determinations.[5] For each of the three samples, SSA reviews 70 allowances and 70 denials per state per calendar year quarter. In its reviews, SSA determines whether decisions have been documented and decided in accordance with its policies and disability criteria. If SSA detects an error in a case (known as a deficiency), it will record the deficiency and return the case to the DDS for correction. SSA assigns each deficiency a code in its computer system according to type of mistake identified.

SSA provided us with the aggregate results of its random sample quality reviews for fiscal years 2017, 2018, and 2019. Specifically, for each state, the number of cases reviewed each year for each of the three reviews, and the number and types of deficiencies identified. We selected these years because they were the most recent for which data were available at the time of our review, and because SSA officials told us that sampling methods for these quality reviews did not change significantly over this period of time.

Analysis and Results

We consulted with SSA officials to determine which deficiencies (as coded in the data) were related to errors in reviewing medical evidence, i.e., errors that could potentially be made by consultants. For each code in the data, officials indicated whether the deficiency code was related to

[4]We excluded three DDSs from our analysis because they reported changing how they classified their consultants (i.e., contractors or employees) or how they paid their consultants during the period of our analysis.

[5]The results of the initial determination reviews are used by SSA to assess state DDS performance accuracy and are publicly reported.

medical deficiencies, non-medical deficiencies (such as errors in determining whether a claimant is engaged in substantial gainful employment), or situational deficiencies (which could be medical or non-medical depending on the details of the case).

The outcome or dependent variables for our model are the state-level deficiency rate for medical deficiencies alone, and for medical and situational deficiencies together. The control, or independent variables in our model are employment type (employees only, contractors only, mix of employees and contractors) and compensation type (incentivizes speed or does not incentivize speed). A model using state-level random effects was also used to control for observations clustered within a state.

Prior to fitting the model, we first examined the distribution of medical and situational deficiency rates. The distribution of medical and situational deficiency rates was positively skewed, meaning that most cases sampled by SSA for quality review were determined to have been free of medical or situational deficiencies. Additionally, we examined the frequency distribution of cases with and without medical or situational deficiencies and performed statistical tests to determine whether significant associations exist between employment and compensation type. We found evidence of a statistically significant association between employment and compensation type, and consequently considered a model using only one of these factors.

Because of the association between consultant employment and pay type, we ran multiple models and found that using pay type alone as the predictor gave the smallest prediction error for both medical deficiencies alone, and medical and situational deficiencies combined. The final models considered used a fixed effect for payment type or employment type and a random effect for state. Neither models considered were a significant predictor of medical deficiency rate alone, nor medical or situational deficiency rate combined at the 0.05 level.

All regression models are subject to limitations. For this model, the limitations included:

- Data analyzed were claims aggregated within states rather than case-level data. Consequently, we are not able to control for case profiles. For example, factors related to the complexity of cases, such as multiple disabilities claimed or an age-related disability claim, could make cases more prone to errors.

- Similarly, data analyzed did not have any information that would allow us to control for assignment of examiner. For example, case level data clustered within examiner would allow us to control for the effect of the examiner on cases.
- Data analyzed did not include profiles for disability claims that would allow us to control for any other influencing variables aside from state, consultant employment type, and consultant pay type. As a result, some variables that may be related to deficiencies are not available in the data.
- Results of our analyses are associational and do not imply a causal relationship. As such, the lack of a statistically significant relationship should not imply that such a relationship does not exist. For example, unknown data quality issues, the unavailability of disaggregated data, or the lack of a relationship could all result in the same findings.

While it is possible that addressing data limitations, such as controlling for additional factors, or combining and analyzing additional years or types of SSA's quality review data could produce a conclusive result, it is also possible that no relationship exists.[6]

[6]Regarding different types of quality review data, we also explored the feasibility of analyzing results of another quality review of DDS decisions that SSA performs, specifically its pre-effectuation review (PER) of allowances. SSA's PER involves a review—required by law—of at least 50 percent of all favorable disability initial and reconsideration decisions. However, SSA uses a predictive model—rather than a random sample—to select cases for the PER. Since the PER does not use a random sample, we were unable to use PER data to identify relationships in the broader population of claims, such as relationships between DDS error rates and DDS medical consultant employment or pay type. Further, due to gaps in SSA's documentation on the predictive model used to select PER cases, we could not determine that SSA's methods and data for selecting the PER sample were sufficiently reliable to identify similar relationships among the population of targeted and reviewed claims.

Appendix II: Comments from the Social Security Administration

SOCIAL SECURITY
Office of the Commissioner

October 15, 2021

Elizabeth Curda
Director, Education, Workforce, and Income Security Issues
United States Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Director Curda:

Thank you for the opportunity to review the draft report "SOCIAL SECURITY ADMINISTRATION: Actions Needed by SSA to Ensure Disability Medical Consultants are Properly Screened and Trained" (GAO-22-103815). We agree with the recommendations.

If you have any questions, please contact me at (410) 965-2611. Your staff may contact Trae Sommer, Director of the Audit Liaison Staff, at (410) 965-9102.

Sincerely,

Scott Frey
Chief of Staff

SOCIAL SECURITY ADMINISTRATION BALTIMORE, MD 21235-0001

Text of Appendix II: Comments from the Social Security Administration

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Sincerely,

Scott Frey Chief of Staff

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Elizabeth H. Curda, (202) 512-7215 or curdae@gao.gov

Staff Acknowledgments

In addition to the contact named above, Michele Grgich (Assistant Director), Daniel R. Concepcion (Analyst-in-Charge), and Adam Windram made key contributions to all aspects of this report. Additional contributors include David Ballard, Dean Campbell, Julia DiPonio, Justin Dunleavy, Gina Flacco, Alex Galuten, Kristy Hammon, Angie Nichols-Friedman, Andrew Nelson, Mimi Nguyen, Jessica Orr, Stacy Ouellette, Michelle Rosenberg, Almeta Spencer, Jean McSween, Frances Tirado, and Adam Wendel.

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