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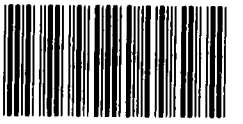
BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

More Diligent Followup Needed To Weed Out Ineligible SSA Disability Beneficiaries



As much as $2 billion annually in Social Security disability insurance payments may go to individuals who are no longer disabled.

The Social Security Administration investigates only a small percentage of its disability program beneficiaries each year to determine whether they are still eligible. Individuals who are not investigated can, if they choose, continue to collect benefits until they voluntarily return to work, die, or reach retirement age. As many as 584,000 persons may not currently be disabled, but they may still be receiving disability benefits.

Although it may not be realistic to expect that all ineligible beneficiaries could be removed from the rolls, substantial savings would be achieved if Social Security stepped up its investigative efforts.

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MARCH 3, 1981

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COMPTROLLER GENERAL OF THE UNITED STATES
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To the President of the Senate and the
Speaker of the House of Representatives

This report discusses the need for the Social Security Administration (SSA) to follow up on disability beneficiaries to determine their continued eligibility. It shows that as many as 584,000 title II disability beneficiaries may be ineligible for program payments totaling $2 billion annually, and it contains recommendations for SSA to take immediate action to reduce the number of ineligible recipients.

On April 18, 1978, we reported that there was a serious weakness in the administration of the disability aspects of the Supplemental Security Income program (title XVI) which allowed medically ineligible recipients to go undetected. In this report, we focused primarily on SSA's efforts to review the continuing eligibility of disability insurance program (title II) beneficiaries.

We are sending copies of this report to the Director, Office of Management and Budget; the Secretary of Health and Human Services; and the Commissioner of Social Security.

Comptroller General
of the United States

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COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

MORE DILIGENT FOLLOWUP NEEDED TO WEED OUT INELIGIBLE SSA DISABILITY BENEFICIARIES

D I G E S T

The Social Security Administration (SSA) has not adequately followed up on Disability Insurance beneficiaries to verify that they remain disabled. It has limited its reviews--referred to as Continuing Disability Investigations (CDIs)--to a small percentage of beneficiaries. Most never have their eligibility reviewed and can remain on the rolls until they voluntarily return to work, reach age 65, or die. (See pp. 5 and 6.)

Even beneficiaries who met the criteria for reexamination have not always been investigated. Some were never scheduled for reexamination; others were scheduled but never reexamined. For example, in a 14-percent sample of all disability awards in 1975, 52 percent of the scheduled medical reexaminations were never done. GAO estimates that from that year alone there could be from 5,770 to 12,630 ineligible beneficiaries who are still on the rolls because scheduled reexaminations were not performed. (See p. 14.)

As a result of SSA's limited followup activity and poor management of the CDI process, as many as 584,000 beneficiaries who do not currently meet SSA's eligibility criteria may be receiving disability benefits. These beneficiaries represent over $2 billion annually in Trust Fund costs. Since SSA decisions on the continued eligibility of Disability Insurance beneficiaries are subject to appeal, it may not be realistic to expect that all these beneficiaries would be removed from the rolls. However, substantial savings could be achieved if SSA focused on this problem. (See pp. 7 and 8.)

Furthermore, inefficiencies in SSA's disability investigation program often result in program overpayments. In 1979, problems related to the investigation process contributed to about $77 million in overpayments, or about 44 percent of all Disability Insurance program overpayments for that year. (See p. 13.)

Realizing that it has not adequately monitored the disability rolls, SSA plans to begin identifying persons not currently disabled and to better manage the investigation process to reduce the number of persons not disabled who are still receiving benefits. In addition, legislation passed in 1980 will require SSA, beginning in January 1982, to review the eligibility of every beneficiary at least every 3 years, unless the State examiner determines that the beneficiary is permanently disabled.

Although these are needed actions, GAO questions whether SSA is moving quickly enough and devoting enough resources to purge the Disability Insurance rolls.

In the past 2 years, SSA has concentrated on reexamining Supplemental Security Income disability cases that were converted in 1974 from the States to SSA. However, the magnitude of the Disability Insurance problem and the greater savings from correcting it now require that SSA give more priority to reevaluating this caseload. Because of limited resources, this may mean postponing further review of Supplemental Security Income conversion cases.

Accordingly, GAO recommends that SSA direct all of its additional $42 million fiscal year 1981 funds for continuing disability investigations to remove the nondisabled from the Disability Insurance rolls, and direct future budget outlays to the Disability Insurance rolls until the problem is under control. (See p. 11.) GAO also recommends other actions to improve the overall management of the CDI process. (See pp. 22 and 23.)

AGENCY COMMENTS

SSA agreed that additional efforts are needed to review disability cases and has begun to focus on high-risk cases. However, SSA continues to budget most of its limited resources on Supplemental Security Income disability cases. (See p. 11.)

SSA also said it plans to take the necessary corrective actions to improve the management of the CDI process. (See p. 23.)

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ABBREVIATIONS

ACID	Automated Continuing Investigation of Disability
CDI	Continued Disability Investigation
DI	Disability Insurance
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HHS	Department of Health and Human Services
MBR	Master Beneficiary Record
SSA	Social Security Administration
SSI	Supplemental Security Income

CHAPTER 1

INTRODUCTION

The Social Security Administration (SSA) administers two benefit programs for disabled persons. SSA's Disability Insurance (DI) program was 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 are prevented from continuing payments into their social security account. In 1956 the program was expanded to authorize cash benefit payments to the disabled.

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

To be 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 Congress established a separate Disability Insurance Trust Fund to specifically identify the costs of the DI program. All disability insurance benefit payments and associated administrative costs are disbursed from this fund. The DI benefit structure is the same as that used in SSA's Retirement Insurance program.

Eligibility under the SSI program is limited by income and resources. The limits vary by marital status and living arrangements. The SSI program is financed from Federal general revenues and is intended to provide a minimum income for eligible recipients. States can supplement Federal SSI benefits with their own funds.

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 because 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 both. Work may be considered substantial even if it is performed part time and is less demanding, less responsible, or pays less than the individual's former work.

A claimant can apply for disability benefits at any SSA 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, which carry out

the disability determination process under agreements with the Department of Health and Human Services (HHS).

The State agencies' primary function is to develop medical, vocational, and other necessary evidence; evaluate the evidence; and make a determination as to the applicant's disability. The State agency uses the disability and vocational report prepared by the SSA 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 the guidelines for developing and processing claims are furnished to the State agency by SSA. The Federal Government bears the costs incurred by the State agencies in making disability determinations.

Over the past several years, both programs have grown considerably. Between fiscal years 1972 and 1979, the number of beneficiaries increased from 3.3 million to 7.2 million and benefits paid increased from $4.0 billion to $17.9 billion. During this period, the cost of program administration by State agencies increased from $68.2 million to $311 million and the number of State employees increased from 4,400 to 9,600.

Disability Programs Benefits Paid

Fiscal year	Beneficiaries (end of year) (note a) Title II	Title XVI	DI Trust Fund	SSI general revenue	Total	Program administration by State agencies Cost	Employees
	(millions)			(billions)		(millions)	(thousands)
1972	3.3	-	$ 4.0	$ -	$ 4.0	$ 68.2	4.4
1973	3.6	-	5.2	-	5.2	80.4	6.3
b/1974	3.9	1.7	6.2	1.8	8.0	146.8	10.3
1975	4.4	2.0	7.6	3.0	10.6	206.8	10.1
1976	4.6	2.1	9.2	3.4	12.6	228.3	9.3
1977	4.9	2.2	11.1	3.7	14.8	254.2	9.4
1978	4.9	2.2	12.3	4.1	16.4	280.0	9.6
1979 (est.)	4.9	2.3	13.6	4.3	17.9	311.0	9.6

a/Figures for title II include disabled workers and their dependents. The number of primary disabled workers for 1979 was 2.9 million.

b/Payment of SSI benefits started in January 1974.

Beneficiaries can be terminated from the DI program because of

--attainment of age 65, at which time they are put on the retirement insurance benefit roll;

--death;

--medical recovery; or

--demonstrated ability to engage in substantial gainful activity.

This report discusses the latter two events and SSA's process for dealing with them.

THE CONTINUING DISABILITY INVESTIGATION PROCESS

The Continuing Disability Investigation (CDI) process is SSA's way of identifying beneficiaries who may have medically recovered or regained the ability to work and assessing their continuing eligibility for disability benefits.

Continuing medical eligibility is evaluated through the medical reexamination diary process. Since eligibility for SSA's disability programs is not necessarily based on permanent impairments, SSA has identified 17 conditions--such as tuberculosis, fractures, and infections--that have the greatest potential for medical improvement. (See app. I.) At the time of the initial disability determination, State agencies establish a future medical reexamination date ("diary") for beneficiaries with 1 of the 17 conditions. When the diaries mature, State agencies are to reevaluate beneficiaries' medical condition.

A CDI is also done when SSA learns that a beneficiary has returned to work. A beneficiary's return to work may indicate that the impairment has improved or that the individual has the capacity to work despite the impairment.

In 1978 SSA did CDIs on about 141,256 of the 2.9 million disabled workers on the DI rolls and terminated benefits in 72,606 (51.4 percent) of the cases reviewed.

OBJECTIVE, SCOPE, AND METHODOLOGY

In an April 18, 1878, letter to the Secretary of Health, Education, and Welfare (HEW), 1/ we reported that there was a

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1/Since May 4, 1980, HEW activities discussed in this report are the responsibility of HHS.

serious weakness in the administration of the disability aspects of the SSI program which allows medically ineligible recipients to go undetected. This earlier review did not look at the eligibility of DI beneficiaries.

In this report, we focus primarily on SSA's efforts to review the continuing eligibility of DI beneficiaries. We also address SSA's actions to correct the deficiencies noted in the April 18, 1978, report. We reviewed program policies and procedures, reports, and studies at SSA headquarters in Baltimore, Maryland. In addition, to gain a better understanding of the CDI process and the role of various components involved, we visited an SSA district office in Cincinnati; the SSA regional office in Philadelphia; the SSA Technical Assistance Section in Philadelphia; and the State Disability Determination unit in Columbus, Ohio.

According to 1977 and 1978 SSA work group reports, delays in completing CDIs and terminating benefits timely were major causes of overpayments in the DI program. To better understand the problems SSA was having with the CDI process, we selected a random sample of 120 cases with overpayments resulting from the process to determine if the problems still existed and whether corrective actions were needed. The sample was drawn from a universe of 754 overpayment cases where the disabled workers' social security numbers originated in Kentucky, Maryland, or Ohio, and the overpayment was identified by SSA from January 1, 1979, to September 27, 1979. SSA was able to locate and give us 49 case files of the cases selected.

Because one of the key features of the CDI process is the medical reexamination, we attempted to determine if all scheduled medical reexaminations were being done. To do so, we matched SSA's 1975 Continuous Disability History Sample file, which contains data on a sample of beneficiaries entering the DI rolls--including scheduled medical reexaminations--to a record of CDIs performed and their outcome. SSA refers to the latter record as the "833" file, and the record is current through the third quarter of fiscal year 1979. We also matched the social security number of beneficiaries who were scheduled for a medical reexamination with the Master Beneficiary Record (MBR) to determine how many were in current pay status. Because medical CDIs involve temporary type disabilities, about one-half of the beneficiaries should have medically recovered and been terminated from the DI benefit rolls.

CHAPTER 2

SSA NEEDS TO FOLLOW UP ON DISABILITY BENEFICIARIES TO DETERMINE THEIR CONTINUED ELIGIBILITY

Based on a nationwide sample case review recently conducted by SSA, we estimate that the Trust Fund could be losing over $2 billion a year because as many as 584,000 persons currently collecting disability benefits--20 percent of the 2.9 million primary beneficiaries on the DI rolls--may not meet SSA's current eligibility criteria. Most of them would not be subject to any followup reexamination or reevaluation and can, if they choose, continue to collect benefits until they voluntarily return to work, die, or reach retirement age. This condition exists because, annually, SSA investigates the eligibility of only a small percentage of DI beneficiaries. The majority of beneficiaries on the rolls (about 80 percent) are never reevaluated.

Because of concern expressed by congressional committees and us, SSA now recognizes that its followup on DI beneficiaries has been inadequate. This condition was further reinforced with SSA's meetings with private insurance industry representatives who advised SSA that the only way to manage a disability program is by frequently contacting beneficiaries and verifying that they remain disabled. SSA has taken steps which should prevent the future buildup of ineligible persons on the DI rolls. SSA must give more priority to identifying the nondisabled currently on the rolls and terminating their benefits.

SSA HAS NOT ADEQUATELY REVIEWED THE DI CASELOAD

SSA has placed little emphasis on reviewing the eligibility of beneficiaries once they are on DI rolls. As shown in the following table, only a small percentage of the disabled workers on the rolls are given a medical reexamination each year. This percentage ranged from 3.0 in 1973 to 3.6 in 1978, except in 1974 when SSA reexamined only 1.5 percent on the rolls. The advent of the SSI program in 1974 created a large workload pressure causing medical reexaminations to be lower that year.

Calendar year	Disabled workers on rolls at beginning of year	Medical reexaminations done	Percent of disabled workers reexamined	Work activity and other eligibility investigations	Percent of disabled workers investigated
1973	1,833,000	60,600	3.3	34,300	1.9
1974	2,017,000	30,200	1.5	35,400	1.8
1975	2,237,000	81,400	3.6	37,800	1.7
1976	2,489,000	75,000	3.0	37,200	1.5
1977	2,670,000	89,200	3.3	37,300	1.4
1978	2,834,000	100,211	3.5	41,045	1.4

Most beneficiaries never have their impairments reevaluated after initial eligibility is established. This may be the result of the wording in the Social Security Claims Manual, which cautions State agencies that most allowed cases involve chronic, static, or progressive impairments, subject to little or no medical improvement. Further, the manual states that in other cases, even though some improvment may be expected, "the likelihood of finding objective medical evidence of recovery has been shown by case experience to be so remote as not to justify establishing a medical reexamination diary." State agencies are instructed to schedule medical reexaminations only if the impairment is 1 of the 17 specifically listed. Historically, the percentage of new awards diaried has been small. From 1973 to 1977, only 18 to 26 percent of initial awards were scheduled for medical reexaminations. This means from 74 to 82 percent of the workers who came on the rolls during that period would probably never have been reevaluated--unless they returned to work and SSA became aware of the work activity.

According to SSA officials, this limited followup activity is due, in part, to the philosophy that has existed in SSA. When the DI program authorized benefits in 1956, the definition of disability was very restrictive and specified that the impairment had to be total and permanent or expected to result in death. Therefore, the DI program was patterned similar to SSA's retirement program and the emphasis was on paying benefits. In 1965 the definition of disability was liberalized to include persons with less permanent impairments--expected to last at least 12 months. However, SSA management did not put added emphasis on followup activity.

Surveys find many not disabled

In the past 2 years, studies of SSA's disability programs concluded that many beneficiaries may not currently be disabled.

Our April report 1/ to the Secretary of HEW was the first to show that a serious problem existed. We found that at least 24 percent of 402 SSI cases converted from the State disability programs and 10 percent of another 175 SSI cases were not disabled. The important point about these cases was that most (77 percent) of those found to be ineligible were not scheduled for a medical reexamination and probably would never have been detected by SSA.

Prompted by our report, in 1979 SSA reviewed a 5-percent sample of SSI conversion cases in the State of Washington and terminated benefits in 11.8 percent of the cases reviewed. SSA is now reviewing the remaining 7,600 Washington conversion cases. In addition, SSA took a nationwide sample of 13,000 conversion cases in March 1979 to determine which other States warrant a complete review. SSA expects the termination rate from this sample to be about 12.4 percent. SSA plans to review about 310,000 more conversion cases through fiscal year 1983.

Ineligibility in the DI program--a costly problem

Our April 1978 report did not address the DI program, but it did conclude that:

> "* * * 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 DI program and go undetected."

SSA is finding this to be true, and it seems to be a more costly problem in the DI program than in the SSI program.

In July 1978 SSA began a review of DI cases which were not scheduled for a medical reexamination. Although this study was suspended after about 6 months to concentrate on the SSI conversion cases, SSA found that 11 percent of about 1,000 cases reviewed before the study's suspension were no longer eligible for DI benefits.

SSA has recently completed a comprehensive study of the DI rolls. This study--the Disability Insurance Pilot--was designed to test methods that SSA could use in an ongoing program for measuring DI payment accuracy. Through the Pilot, SSA also intended to develop indications of the major types and causes of payment error in the DI program.

SSA randomly selected 3,000 sample cases that were representative of the DI population, collected medical evidence, and in some cases visited beneficiaries in their homes to interview

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1/HRD-78-97.

them about their impairments. Using this evidence, SSA examiners and physicians determined that about 20 percent of the sample did not meet SSA's current eligibility criteria in the sample month, April 1979.

Based on this ineligibility rate, there could be about 584,000 persons on the DI rolls who may not meet the program's eligibility criteria. Since the Pilot study showed that the average monthly payment was about $350, SSA could be paying over $2 billion a year to persons not eligible for the program. This figure does not include the cost of Medicare benefits.

Although the Pilot study showed that 20 percent of the beneficiaries on the DI rolls are not disabled, the actual termination rate probably would not be that high. In some cases, while the State agencies might determine that the beneficiary is no longer disabled, the decision could be overturned through the appeals process. However, we believe the Pilot study is a good indicator--probably the best one available--that ineligibility in the DI program is a costly problem that must be corrected. For example, even if 10 percent of those on the rolls were ineligible and could be removed, the annual savings to the Trust Fund would amount to about $1 billion.

Several factors have contributed to the large number of nondisabled on the DI rolls. First, SSA believes that because of heavy workloads brought about by the SSI program and limited SSA quality assurance in 1974 and 1975, ineligible persons were erroneously placed on the rolls in these years. In addition, SSA had a policy in effect from 1969 until 1976 called the LaBonte principle (named after an administrative law judge's hearing decision) which stated that terminations had to be based on documentation which supported medical improvement. Under this principle, all initial disability decisions were presumed to be correct--even though this was not always true. As a result, when SSA discovered through medical reexamination that a person had been erroneously awarded DI benefits and was never disabled, the individual was allowed to remain on the rolls because there was no evidence of medical improvement. Finally, because SSA did not have an effective information system to enable it to manage the CDI process, many beneficiaries who met the diary criteria were never scheduled for a medical reexamination and many scheduled medical reexaminations were never done. (See ch. 3.)

SSA HAS INITIATED EFFORTS TO IDENTIFY THE NONDISABLED

As a result of our studies, SSA has concluded that to effectively manage a disability program it must frequently contact beneficiaries and verify that they remain disabled. Since 1979, SSA has acted to strenghthen the CDI process and prevent the future buildup of nondisabled on the DI rolls.

SSA plans to increase the number of medical reexaminations and improve their cost effectiveness. By better identifying the characteristics of workers likely to medically improve or otherwise be found ineligible, SSA hopes to increase the number of terminations resulting from medical reexaminations.

In an effort to reassess its guidelines for establishing medical diaries and increase the number of cases that are medically diaried, SSA began the Medical Reexamintion Improvement Test. This test gives the State agency professional staff the discretion to establish, in addition to the diary categories, a medical reexamination diary in any case where medical recovery appears likely. The test also raised questions about the adequacy of the current diary criteria, and SSA is making this option a permanent part of the program.

In fiscal year 1980, SSA began a review of 25,000 DI cases not currently scheduled for medical reexamination. Through this study, SSA intends to identify the characteristics of individuals most likely to be found ineligible. Such characteristics include the year of initial disability determination, the worker's age, impairment, and geographic location. The complete results of this study will not be available until spring 1981. SSA also planned to review 25,000 SSI conversion cases in fiscal year 1980. A total of $10.3 million has been budgeted for these two studies--$3 million for the DI probe and $7.3 million for the SSI effort.

SSA has budgeted $42 million for fiscal year 1981 to reevaluate an additional 100,000 SSI conversion cases. The cases reviewed may be a mix of DI and SSI cases, depending on the results of the 1980 probes. The supplemental funds will be used to purchase consultative medical examinations and to meet the additional personnel costs of the State agencies that arrange for the medical reexaminations to determine if the disability continues.

The Congress, also concerned about SSA's review of the DI caseload, passed legislation in 1980 that will result in SSA doing more continuing eligibility reviews. Unless the State agency examiner determines that the worker is permanently disabled, SSA must review the status of every beneficiary at least once every 3 years.

SSA should give more priority to identifying the nondisabled on the DI rolls

While SSA has taken steps to better manage the DI caseload, the question remains--can SSA move faster to identify the nondisabled currently on the DI rolls and prevent the annual loss of billions in Trust Fund money?

SSA plans to spend an additional $42 million in fiscal year 1981 for both the DI and SSI efforts. The SSA official responsible for improving the CDI process said that this was a realistic figure based on the State agencies' capabilities to hire, train, and house new employees. He said CDI cases are generally handled by the more experienced personnel in the State agencies, while the new examiners are trained to adjudicate initial claims. If new examiners are not properly trained, the quality of the initial decisions could decline, causing more nondisabled to come on the rolls. This happened in 1974 and 1975 when the SSI program began and is one cause of the current problem. He also said that many State agencies' facilities are already overcrowded and lack the space for many additional personnel.

With these limitations, SSA must decide how to best use its resources. In our opinion, SSA should give priority to purifying the DI rolls because of the potential savings involved. In the past 2 years, SSA has used most of its additional CDI resources on the SSI conversion caseload. Based on the results of the recently completed Pilot study, however, it would be more cost beneficial to concentrate future resources on the DI program. The average monthly benefit paid in SSI conversion cases is about $210 and in federally determined SSI cases about $148. In DI cases, the average benefit is about $397.

Furthermore, SSA is experiencing a high reversal rate in those SSI conversion cases where it terminated benefits. For example, the initial cessation rate in 10,450 cases reviewed from the nationwide conversion case study was about 27 percent (2,822 cases). However, 72 percent (2,032) of those with cessation decisions appealed, and about 63 percent (1,280) of those that appealed had the decision reversed. SSA officials stated that SSI recipients often have little or no work experience and many of those that are removed from the SSI rolls may begin receiving payments from other public assistance programs.

SSA will have enough information to effectively target the additional resources on the DI caseload in fiscal year 1981. Information should be available from the DI Pilot and the first increments of the 25,000 cases currently being probed. By matching the Initial Determination File and the CDI file, SSA can also identify beneficiaries who were scheduled for a medical reexamination but who were never reexamined. In addition, SSA knows that 1974 and 1975 were error-prone years. A review of cases placed on the rolls during those 2 years could also be fruitful.

Disability diagnosis not recorded on the MBR

SSA efforts to identify and remove nondisabled workers from the DI rolls will be impeded because the beneficiaries' disabling

conditions are not recorded on the MBRs. Even though its ongoing studies may identify certain impairments that are likely to improve, SSA will have no way of knowing which beneficiaries have these impairments. The recording of disability diagnoses on the MBRs should improve the efficiency and effectiveness of SSA's efforts to target resources.

CONCLUSIONS AND RECOMMENDATIONS

SSA has not adequately monitored the disability rolls, but has initiated plans to increase the number and effectiveness of investigations. Because of the magnitude of the problem, delays in carrying out these plans could be costly. SSA should give higher priority to (1) identifying the nondisabled currently on the rolls and (2) improving the CDI process to prevent this number from increasing.

We recommend that the Secretary of HHS direct the Commissioner of Social Security to expedite efforts to reevaluate the DI rolls and to provide the necessary resources to support such efforts because of the potential savings. In this regard, SSA should use all of the additional $42 million fiscal year 1981 CDI funds to remove the nondisabled from the DI rolls and direct future budget outlays to the DI rolls until the problem is under control. To facilitate its current efforts and future management of the DI rolls, SSA should also begin coding the nature of the beneficiaries' impairments on the MBRs.

AGENCY COMMENTS AND OUR EVALUATION

SSA agrees that additional efforts are needed to review disability cases, and as we suggested, it has begun using available information to focus on high-risk title II cases. SSA is identifying high-risk cases and in the next few months expects to initiate investigations on 80,000 title II cases. In commenting on our report, SSA stated that:

> "We also concur with the present GAO report that from a cost-benefit perspective, it is wise to focus as quickly as possible on title II cases because the title II payment levels are higher."

Notwithstanding the above statement, SSA continues to budget its limited resources on SSI rather than title II case reviews--100,000 in each of fiscal years 1981 and 1982. This is not consistent with our recommendation and is not the most cost-effective use of limited SSA resources.

SSA also agrees that information concerning the nature of an individual's impairment should be retained, and it is exploring

methods, other than placing this information on the MBR as we recommended, that will give greater flexibility in selecting and managing this workload. SSA is conducting a staff analysis and is expecting a decision by early summer 1981. Since the beginning of the DI program in 1956, SSA has not coded the type of medical impairment on its MBRs, and even today it does not have a system to identify the impairments of the disabled population. Therefore, every effort should be made to obtain this information as soon as possible.

CHAPTER 3

SSA NEEDS A BETTER SYSTEM TO ASSURE THAT ELIGIBILITY REVIEWS ARE SCHEDULED AND PERFORMED

The medical reexamination diary process, which is SSA's primary means of identifying and investigating beneficiaries whose impairments are expected to improve, has not been effectively managed. As a result, even beneficiaries who met SSA's limited reexamination criteria were not always investigated--some were never scheduled for reexamination and others were scheduled but never reexamined.

These problems contribute to the loss of Trust Funds paid to the nondisabled. Missed medical reexaminations from 1 year alone may result in as much as $60 million annually in ineligible payments. Despite the severity of this situation, SSA has not given high priority to correcting it.

Furthermore, delays in completing investigations and terminating benefits when warranted, result in program overpayments. In calendar year 1979, problems related to the CDI process contributed to about $77 million in overpayments, or about 44 percent of all overpayments ($174 million) in the DI program for the year.

HOW MEDICAL REEXAMINATIONS ARE DONE

At the time of the initial disability determination, State agencies establish a future medical reexamination diary in cases where the beneficiary is expected to improve medically. The examiner records the scheduled reexamination date in the case folder and mails the folder through the district office to SSA headquarters. The diary date is then entered into SSA's Automated Continuing Investigation of Disability (ACID) system. Two months before the diary date, the ACID system flags the case. SSA headquarters personnel attempt to locate the case file and mail it to the State agency for investigation. Based on information provided by the beneficiary and current medical evidence, the State examiner determines if the disability still exists. The determination and folder are mailed back to SSA headquarters for review. SSA notifies the beneficiary of the results and terminates benefits if the disability has ceased.

In 1978, SSA made just over 100,000 medical reexaminations and terminated benefits in about 47,600 cases (47.5 percent).

Breakdowns in the medical reexamination process

The medical reexamination diary process has not worked as it should--many scheduled medical reexaminations are never done--because SSA did not have an effective management information system to monitor the process. SSA officials did not know the extent of this problem, but believed it was serious. We confirmed this belief.

In a 14-percent sample of all awards in 1975, 1/ 15,746 cases (18 percent of the sample) were scheduled for medical reexamination. Of this total, 8,254 (52 percent) were never done. Many of these beneficiaries (5,318) who were expected to medically recover but were never reexamined are still on the disability rolls. Based on the termination rate in medical reexamination cases in the last 4 years, there could be from 1,154 to 2,526 individuals who could receive from $5.5 million to $12.1 million in ineligible payments annually. Projecting these figures to the universe of all scheduled medical reexaminations for 1975, there could be from 5,770 to 12,630 beneficiaries who should not be on the rolls and who receive from $27.7 million to $60.6 million in ineligible payments annually.

Furthermore, when reexaminations are done, they are not always timely. One State agency study in 1979 demonstrated substantial delays in initiating continuing disability investigations in title II cases. According to this study, 48 percent (229 cases) arrived at the State agency after the scheduled reexamination date. Of these, 79 cases (about 34 percent) were 6 months or more after the diary date. In our limited review of 49 randomly selected overpayment cases, 25 had medical reexamination diaries scheduled. Thirteen of the 25 were sent to the State agency after the scheduled reexamination date. Most of the cases were 1 to 3 months late. In addition, four cases were never sent.

These problems exist because of a lack of effective internal controls over the process. SSA has no control mechanisms to ensure that all reexamination diaries are entered into the ACID system. In early 1978, SSA realized that district offices were failing to record the diary dates in a "significant number of cases."

Furthermore, even when the diary dates are entered into the system, SSA has not monitored the cases to ensure that the investigations are done and done timely. The monthly diary alerts are

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1/SSA's Continuous Disability History Sample is an annual sample of new applicants for DI benefits. The sample rate varies from year to year depending on the total number of workers allowed benefits.

individual pieces of paper, used only to locate and mail the cases. There are no consolidated lists of alerts generated monthly or lists of outstanding investigations showing age and location. The ACID system produces followup notices every 3 months after the initial alert until the investigation is completed. However, these notices--also individual sheets of paper--are not sent to the State agency that has the case, and SSA does not use them as a management tool. If the investigation is not completed and cleared from the system 12 months after it was due, the ACID system automatically destroys the record. When this happens, there is no evidence to show that a reexamination was ever scheduled.

Before the ACID system was implemented in October 1977, the situation was worse. Before that time, the CDI process was controlled by the MBR system. The MBR system erased the record of medical reexamination date at the same time it generated the alert that the reexamination was due.

There may be many beneficiaries who met the diary criteria, but who were never scheduled for a medical reexamination. For example, in 1973 only 18 percent of individuals receiving initial awards were scheduled for medical reexamination. Although the diary criteria remained the same, the rate rose to 26 percent by 1977. Fewer cases were diaried from 1973 to 1976 because of the emphasis on processing initial claims quickly. The CDI process was given low priority, and not all cases meeting the diary criteria were scheduled for reexamination--medical reexaminations were scheduled only in cases most likely to be terminated. During that period, SSA did not review State agency decisions to determine if all appropriate cases were diaried.

Medical reexamination process not likely to improve soon

In 1979, as a result of concerns expressed by the House Ways and Means Subcommittee on Social Security and our report (HRD-78-97), SSA recognized that its followup activity on DI beneficiaries was inadequate and that there were problems with the medical reexamination process. As discussed below, however, improvements to the process are not likely to be soon.

Management responsibility for the CDI process was given to the Office of Disability Programs in early 1979. This office is attempting to develop the management information necessary to manage the process. CDI program managers have requested that SSA data systems personnel make changes that will have the ACID system produce monthly, quarterly, and annual lists showing the number of outstanding investigations and their age and location. Lists showing all investigations that are 90 days or more overdue would be sent monthly to the SSA Regional Commissioners for followup action. The ACID system would be interfaced with SSA's Case Locator

System and followup notices sent directly to the field component processing the cases. The ACID system is to be reprogramed so that it will not erase the record of medical diary date after 12 months, as it now does. To help alleviate the problem of diaries not being entered into the ACID system, SSA had tested a procedure in May 1980 requiring all cases to have an entry in the MBR diary field--either the reexamination diary date or a code indicating that none was scheduled. National implementation of this procedure began in September 1980. SSA will also try to identify all cases where a medical reexamination was scheduled but never done.

However, actual implementation of most of these measures may take a long time. Because of other priorities within SSA, none of the planned improvements to the ACID system had been started as of February 1981, nor were there any plans to start them soon.

DELAYS IN WORK ACTIVITY INVESTIGATIONS CAUSE OVERPAYMENTS

SSA also does continuing disability investigations when it learns that beneficiaries have returned to work. This process, like that for investigating medical recovery, needs management attention. Delays in initiating and completing work activity investigations, and in terminating benefits when warranted, are creating large program overpayments.

A disability beneficiary's return to work may mean that eligibility has ceased. Therefore, SSA must evaluate the work activity in terms of duration, duties performed, and pay received, and it must determine if the beneficiary's impairment has improved or is less severe than alleged, or if the person is working despite the impairment. Generally, beneficiaries are given a 9-month "trial work period" to test their ability to work and hold a job. After the beneficiary has worked 9 months--not necessarily consecutively--SSA investigates the case to determine if the work continues and if it is "substantial gainful activity." SSA defines this activity as "performance of significant duties over a reasonable period of time for remuneration or profit (at or above $300 per month)." Eligibility ceases the first month the beneficiary engages in substantial gainful activity after completing the trial work period. Benefits, however, are paid during the 9 months of trial work, in the month eligibility ceases, and for 2 additional months--a total of 12 months.

SSA learns of work activity from several sources--the beneficiary reports from the States that an individual has completed a vocational rehabilitation program and was placed into competitive employment, social security earnings records, and third parties. Investigating work activity cases depends on when SSA learns the

beneficiary has returned to work. If information about a beneficiary's work activity is received before the individual completes the trial work period, SSA enters a diary date into the ACID system. The diary date is the month and year that the beneficiary is expected to complete the trial work period. The procedure from this point is similar to the medical reexamination process.

When SSA learns about a beneficiary's work activity after the trial work period has ended or in cases where the beneficiary was not entitled to one (i.e., the beneficiary previously used a 9-month trial work period), the diary process is not used. In these cases, the continuing disability investigation should be done immediately. In 1978, SSA made about 27,372 investigations involving work activity and terminated benefits in 17,682 cases (65 percent).

Problems causing delays in SSA's work investigation process

In both 1977 and 1978, SSA work groups looked into the problem of overpayments in social security programs. The work groups determined that inefficiencies in the CDI process were the primary cause of overpayments in the DI program and that one of the major problems was the difficulty in completing work investigations timely and terminating benefits when warranted. Thirty-four of the 49 overpayment cases reviewed were related to work activity investigations. Based on these cases and other documentation obtained during our review, it appears that the problem still exists and that delays are at least partially due to

--the complexity of an investigation process that involves various SSA components and the need to mail case folders between these components,

--lack of needed information at district offices concerning beneficiaries' work activity, and

--a lack of emphasis within SSA on terminating benefits.

Process is complex

SSA headquarters, district offices, and in some cases, State agencies play a role in work activity investigations, and cases are mailed back and forth between these components. The logistics of this process make it difficult to complete investigations timely. For example:

> A 56-year-old beneficiary with a statutory blindness disability and an undiagnosed disease returned to work in April 1977. SSA was notified of his return to work by a July 11, 1977, Vocational Rehabilitation completion report and an August 7, 1977,

self-report from the beneficiary. SSA headquarters requested the district office to investigate the case in December 1977--the final month of the trial work period. It took the district office until April 10, 1978, to complete the investigation. The district office found that the beneficiary had worked continuously and benefits should have been terminated a month earlier in March 1978. Because of an SSA policy concerning statutory blindness, only SSA headquarters can terminate benefits. The investigation materials and the case file were mailed separately to SSA headquarters.

On April 27, 1978, SSA mailed the case file back to the district office requesting another work activity investigation. The district office mailed the case back to SSA headquarters on May 10, 1978, noting that the original investigation material was mailed and another investigation would be a waste of time.

On June 7, 1978, SSA sent a third request for investigation to the district office stating that the original development materials had been lost. The district office completed the second investigation on October 25, 1978. SSA headquarters reviewed the case and determined that eligibility had ended. Benefits were terminated as of January 1979.

It took SSA over a year to complete this investigation and terminate benefits. Even though the beneficiary reported his work activity in a reasonable amount of time, he was required to repay $2,567.80 for overpayments received from April to December 1978.

The process is even more complex and the potential for overpayment is even greater when a beneficiary returns to work after unsuccessfully completing a prior trial work period or is not entitled to a trial work period. Such cases require an immediate investigation which SSA seldom accomplishes under the current system. For example:

A 27-year-old beneficiary with a disability of multiple fractures completed 9 months of trial work in November 1977. At that point his work was interrupted when he was hospitalized.

This individual returned to work in May 1978 and reported this to the district office on July 20, 1978. At that point, the district office had little time to take the necessary action to prevent the overpayment. The beneficiary's eligibility had

ceased in May, the first month he engaged in substantial gainful activity after completing the trial work period. Accordingly, his benefits should have been terminated as of August 1978.

It took the district office from July 20, 1978 (when the beneficiary reported) to August 28, 1978, to record the beneficiary's work activity. Since the district office did not have the case folder, it was unaware that the trial work period had expired and mailed the information to SSA headquarters without suspending benefits.

Headquarters personnel reviewed the case on October 24, 1978, and even though the case had been in overpayment status since August 1978, they did not suspend benefits. Instead, the case was mailed back to the district office on October 30, 1978, for a complete investigation. The district office did not finish the investigation until January 10, 1979, and apparently by mistake, mailed the case to the State agency. The State agency forwarded the case to SSA headquarters on January 20, 1979.

SSA headquarters mailed the case back to the district office on February 20, 1979 (reason unknown), and benefits were finally terminated as of May 1, 1979.

Because it took SSA from July 1978 to May 1979 to terminate benefits, the beneficiary was charged with an overpayment of $3,637--even though the overpayment was caused primarily by SSA's delays.

District offices lack up-to-date information

One obstacle to terminating benefits promptly, as seen in the above-mentioned example, is the fact that district offices generally do not have the disability case folders or up-to-date information about beneficiaries' work activity during the disability period. Consequently, when the beneficiary reports work activity, the district office sometimes provides incorrect or misleading information about continued entitlement to benefits. Beneficiaries are confused and frustrated when this information is later contradicted by SSA headquarters, and they are required to repay benefits they were not entitled to.

SSA is failing to act quickly when information is available

Another problem causing overpayments is SSA's failure to act quickly to terminate benefits, even when an overpayment is obvious.

Several times in the above-mentioned example either the district office or SSA headquarters could have reduced the amount of the overpayment by terminating the benefits several months earlier. This problem can also be seen in the following example:

> A 42-year-old beneficiary with a disability of agitated depression returned to work in October 1977. The Vocational Rehabilitation Agency completed its report of this work activity on March 9, 1978, and it was received at SSA headquarters in August 1978.
>
> SSA headquarters mailed the beneficiary a questionnaire on September 28, 1978. The beneficiary completed the questionnaire on October 12, 1978, showing that she had engaged in substantial gainful activity since October 1977. Therefore, when SSA received this information the beneficiary had completed the trial work period (July 1978), eligibility had ceased in August, and payments should have stopped in October. However, rather than suspending benefits, SSA headquarters mailed the case to the district office on November 7, 1978, and the case resulted in a 1-month overpayment of $305.

SSA officials stated that the emphasis in the DI program has always been on paying benefits and terminating benefits has been the exception. One SSA official referred us to a statement in the Claims Manual as an illustration of this emphasis:

> "Request the suspension of disability benefits in work issue cases only when the evidence convincingly establishes a basis for cessation of benefits, an overpayment exists or is imminent, and the DO [District Office] expects the completion of the CDI to be delayed. Suspension of disability benefits (including auxiliary payments, if any) is to be processed only after advance notice (in person, by phone, or by mail) under due process procedures. The DO will notify the beneficiary and all auxiliary beneficiaries not living in the same household of any proposed action to suspend benefits before transmitting a suspension request to BDI [Bureau of Disability Investigations]. Do not suspend benefits if cessation is effective for the current month since the beneficiary is entitled to two additional months of benefits after the month of cessation. The DO will not use the suspension procedure when possible reentitlement after a work cessation exists." (Underscoring added.)

In addition, SSA studies show that district office personnel do not always have a good working knowledge of the CDI process and benefit cessation procedures. According to one SSA official, because of the emphasis in SSA policies and the possible adverse reaction from beneficiaries, congressmen, and the press, district offices often refer cases to headquarters for final decision rather than initiating the action to terminate benefits.

To improve the CDI process and reduce program overpayments, SSA must identify and eliminate the delays in doing work activity investigations and terminating benefits. As part of the effort it may be necessary to revise the existing policy and reeducate agency personnel on the importance of terminating benefits promptly when termination is warranted.

Annual wage reporting--a setback to SSA enforcement efforts

Unfortunately, not all beneficiaries are conscientious and report to SSA when they return to work. Beneficiaries' failure to report their work activity was a contributing factor in 12 of the 34 work activity overpayment cases reviewed. SSA no longer has a backup method for detecting earnings when disability beneficiaries return to work but do not report their income.

Until 1978, SSA required that all employers with three or more employees report quarterly the amount paid to each worker. SSA posted the reported earnings to individual accounts and compiled a Summary Earnings Record for all employees. This record was interfaced with the MBR, enabling SSA to identify DI beneficiaries who had returned to work but had not reported their earnings. Generally, SSA learned about beneficiaries' earnings about 6 to 9 months after the work was done and initiated investigations when appropriate.

In 1978, legislation mandated SSA to change the wage reporting from quarterly to annually. Because of the additional delay in receiving wage information under annual reporting, use of this information to identify earnings and to terminate benefits will result in larger overpayments than the quarterly system. For example, because of this change and delays in making the necessary system changes to process the annual report, the 1978 earnings had not been posted to individual accounts as of May 1980. A beneficiary who returned to work in early 1978, but did not report earnings will have received ineligible payments for about 2 years by the time earnings are posted and SSA investigates.

To help reduce the overpayment problem caused by this change, SSA mailed disability beneficiaries notices in August 1978 and October 1979 reminding them to report work activity. SSA believes that, while these efforts were relatively successful, they do not replace the quarterly wage reports.

CONCLUSIONS AND RECOMMENDATIONS

SSA has not effectively managed the CDI process. Thus, even beneficiaries who met SSA's limited medical reexamination criteria were not always investigated--some were never scheduled for reexamination and others were scheduled but never reexamined. Furthermore, beneficiaries who returned to work were often paid benefits they were not entitled to because SSA was slow to investigate and terminate their benefits. Until these problems are corrected, the Trust Fund will continue to lose millions of dollars annually.

Accordingly, we recommend that the Secretary of HHS direct the Commissioner of Social Security to improve the management of the CDI process. Specifically, SSA should:

--Give priority to improving the ACID system so that management will have a comprehensive list of overdue investigations, their age, location, and status.

--Run the Initial Determination File ("831") against the CDI file ("833") to identify and reevaluate those cases where a medical reexamination was scheduled but not done.

--Emphasize the importance of the CDI process and SSA's current position for reviewing the disability caseload and terminating benefits for those no longer eligible, especially by (1) rewriting the section of the Disability Manual pertaining to continuing investigations and removing the restrictive language which may discourage SSA staff from terminating benefits and (2) providing training to district office personnel on the intent and mechanics of the CDI process.

--Improve the district office and State agency capability to do thorough, timely investigations and to terminate benefits when warranted. One such measure would be to provide work activity information on the MBR so the district office can access this information when a beneficiary reports that he or she has returned to work.

--Measure the impact of annual wage reporting on detecting program overpayments and, if warranted, devise alternative methods to identify beneficiaries who returned to work.

--Periodically review cases where overpayments were caused by the CDI process to identify and correct problems causing the overpayments.

We also recommend that the Secretary study the feasibility of storing certain disability cases--perhaps those with "profiles" that indicate potential for medical recovery or work activity--in the

district offices and assigning full responsibility for these cases to claims representatives. Although there would be additional personnel costs, the potential benefits to the disability program, considering that a beneficiary receives from $30,000 to $50,000 over his or her lifetime, should outweigh the costs. We believe the cost effectiveness of the case management approach in selected situations should be evaluated through a pilot test.

Many of the problems discussed in this report could potentially be eliminated by decentralizing case management responsibility to the district offices. The claims representatives in the district offices would be better versed in all aspects of the disability program and could better serve the beneficiary and the Government. Locating and mailing cases across the country would no longer be necessary. There would be a closer relationship between the beneficiary, the claims representative, and the local vocational rehabilitation counselor, thus helping the rehabilitation effort. In addition, the frequency of contact with the beneficiary would be increased, thus:

--Helping overcome the beneficiary's perception that disability benefits will continue permanently.

--Allowing SSA to become aware of the process changes affecting eligibility and payment status.

--Helping SSA meet the legislative requirements to review cases every 3 years.

In general, this decentralized case management could increase responsiveness to the beneficiary and allow SSA to better protect the integrity of the disability rolls.

AGENCY COMMENTS AND OUR EVALUATION

SSA generally agreed with most of our conclusions and recommendations, and plans to take the necessary corrective actions. (See app. II.) In a few cases, however, we believe SSA's comments deserve futher discussion.

Concerning our recommendation that SSA give priority to improving the ACID system, SSA agreed that ACID should be used to control CDI workloads, but is waiting for design modifications to the system. Because of the large sums being paid to potentially ineligible recipients, SSA should place high priority on developing and incorporating the necessary modifications to ACID.

Concerning our recommendation that SSA match the Initial Determination File against the CDI file to identify those cases where a medical reexamination was scheduled but not done, SSA

acknowledged that the CDI process resulted in "some" lost diaries and that better procedures are needed to obtain them. Our matching of the Initial Determination File and the CDI file clearly shows that the problem is more significant than implied by SSA's comment that only "some" diaries were lost. We projected that in 1975 alone 52 percent of the diaried cases were never done and as many as 12,630 beneficiaries could be receiving over $60 million in ineligible payments annually.

Also, SSA does not agree with the methodology we recommended to match the Initial Determination and CDI files because the (1) SSA CDI file does not contain concurrent DI/SSI cases and (2) medical reexamination diaries can be legitimately deleted through a process which does not use the SSA CDI form. SSA believes the best method to identify lost cases may be to match the Initial Determination tape with the MBR. Our recommendation to match these files would give SSA an immediate "high-hit" target group of potentially ineligible persons to investigate. While SSA's suggested methodology may ultimately be more thorough, we are concerned with the timeliness of its implementation. SSA began testing its methodology in April 1980, and as of February 1981, it was continuing its efforts without success.

In commenting on our recommendation to study the feasibility of using case management as a cost-effective approach for managing the DI rolls and returning beneficiaries to work, SSA agreed with the aim of our recommendation and acknowledged the need for improvement in overall case management so the CDIs could be conducted more efficiently. However, SSA expressed concern with maintaining individual case files at the district office level and said it is testing an alternative procedure--a folderless CDI process. If this is successful and the procedure is implemented nationwide, SSA believes the need for district office folder retention would be obviated.

We believe a folderless CDI process would be an improvement; however, our recommendation for testing the case management approach addresses more than the issue of where case files should be retained, it addresses the need for more information on beneficiaries at the district office level and a need for more contact with the disabled population. In other words, SSA should provide timely and continuous assistance to beneficiaries that have potential for medical recovery and for work activity.

SSA DIARY CATEGORIES (note a)

1. Tuberculosis--without pulmonary insufficiency or severe organ damage due to extrapulmonary disease.

2. Functional psychotic disorders where onset is established within the 2-year period preceding the State agency's determination of disability.

3. Functional nonpsychotic disorders.

4. Active rheumatoid arthritis without residual structural deformity.

5. Any case in which corrective surgery is contemplated or where adjudication takes place during the postsurgical convalescent period and recovery can be anticipated. This includes cases involving surgery for heart or kidney disease, nerve root compression, and lumbar (lumbosacral) fusion.

6. Obesity--in and of itself producing manifestations limiting work capacity.

7. Fracture(s) of any bone(s) without severe residual functional loss or structural deformity.

8. All infections.

9. Peripheral neuropathies.

10. Sarcoidosis without severe organ damage (e.g., pulmonary, ocular, renal, etc.).

11. Progressive neoplastic disease is highly probable, but full medical workup falls short of a definitive diagnosis.

12. Neoplastic disease which has been treated and incapacitating residuals exist, but improvement of these residuals is probable.

13. Epilepsy.

a/In December 1980 four new categories of impairments for reexamination have been added: respiratory disease based on frequency of acute episodes, acute leukemia, central nervous system trauma, and back conditions amenable to treatment.

APPENDIX II

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

13 FEB 1981

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Social Security Needs to Follow-Up on Disability Beneficiaries to Determine Their Continued Eligibility." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Bryan B. Mitchell
Acting Inspector General

Enclosure

APPENDIX II

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT ENTITLED, "SOCIAL SECURITY NEEDS TO FOLLOW-UP ON DISABILITY BENEFICIARIES TO DETERMINE THEIR CONTINUED ELIGIBILITY"

General

We are in general agreement with GAO's findings, particularly with GAO's recognition that SSA was aware of many of the problems and has been moving to resolve them.

At the start of 1978, SSA's analyses began to produce trouble signals in the continuing disability programs. These signals were amplified by GAO's 1978 review of the continued medical eligibility of disabled Supplemental Security Income (SSI) recipients. (Some common processes characterize the SSI and the title II disability insurance (DI) programs insofar as continued medical eligibility is concerned.)

SSA management got a better fix on the range of these problems in 1979 and, in that year and 1980, took many steps--beginning some, and completing others--to deal with them.

We acknowledge that much remains to be done to correct this complex situation. SSA believes that the ultimate solution will be the implementation of the periodic review provision of P.L. 96-265--the Social Security Amendments of 1980--effective January 1, 1982. This provision requires that SSA review all "non-permanent" disabled beneficiaries at least once every three years. (Permanently disabled persons are also subject to review but not necessarily every three years).

Without waiting for January 1982, SSA has taken a number of steps to do additional continuing disability investigations (CDIs) to determine whether persons getting title II or title XVI benefits on the basis of a disability are still disabled.

--Completed early in 1980 a review of over 10,000 disability cases that were converted from the State assistance rolls to identify persons who are not disabled,

--Instituted in 1980 a national review (which will be completed by 3/31/81) of 25,000 title II disability cases designed to remove nondisabled people from the rolls and to identify types of beneficiaries most likely to be found ineligible,

--Budgeted in January 1980 to review 130,000 additional CDIs in FY 1981 (nearly doubling the number previously scheduled for review), thus increasing State agency staff to handle increased workloads. This will enable us to remove more ineligibles from the rolls and will enable us to build DDS capacity to handle the increased workloads arising from the periodic review mandate,

--Completed a review of 3000 current title II disabled beneficiaries to determine the DI payment error rate and to permit profiling of high-risk cases, and

--Developed and initiated systems changes to improve our efforts to maintain the integrity of the disability rolls.

We believe these steps, and many others described below, show that SSA is well out in front in dealing with the problems cited in the GAO report and in implementing the periodic review provision of the 1980 disability amendments.

GAO Recommendation

That the Secretary of HHS direct the Commissioner of SSA to expedite efforts to reevaluate the DI rolls and to provide the necessary resources to support such efforts. In this regard, SSA should use all of the additional $42 million fiscal year 1981 CDI funds to remove the nondisabled from the DI rolls. To facilitate its current efforts and future management of the DI rolls, SSA should also begin coding the nature of the beneficiaries' impairments on the Master Beneficiary Records(MBRs).

Department Comment

We recognized that additional efforts were needed to review disability cases, and initiated an expanded effort by budgeting to review the following additional disability cases:

	FY 1981	FY 1982
Title XVI (SSI) Conversion	100,000	100,000
Title II (DI)	30,000	210,000

We believe there is benefit to reviewing current SSI beneficiaries who were converted from the State to the Federal SSI program in 1974 to assure that they continue to be disabled--as GAO recommended in 1978. SSA has already identified over 50,000 SSI conversion cases for review. We also concur with the present GAO report that from a cost-benefit perspective, it is wise to focus as quickly as possible on title II cases because the title II payment levels are higher. To do this effectively we need to be able to identify high-dollar error title II cases. To that end SSA has recently developed profiles that can be used to identify high-dollar error title II cases. SSA is in the process of identifying cases that conform to these profiles and in the next few months expects to be in a position to initiate CDIs on 80,000 title II cases.

The level of effort devoted to continuing disability investigations and the distribution between title II and title XVI cases for 1981 and future years is presently being assessed as part of the Administration's budget review. Details will be forthcoming as part of the President's proposed budget modification for FY 1981 and 1982.

We also agree that information concerning the nature of an individual's impairment should be retained. We are exploring ways of doing this other than the method recommended. Some of these could provide the advantage of

greater flexibility in the selection and management of this workload than could the MBR. Staff analysis is underway which should permit a decision by early summer.

GAO Recommendation

That the Secretary of HHS direct the Commissioner of SSA to improve the management of the CDI process. Specifically, SSA should:

--Give priority to improving the Automated Continuing Investigation Diary System so that management will have a comprehensive listing of overdue investigations, their age, location, and status.

--Run the Initial Determination File ("831") against the CDI File ("833") to identify and reevaluate those cases where a medical reexamination was scheduled but not done.

--Emphasize the importance of the CDI process and the Administration's current position for reviewing the disability caseload and terminating benefits for those no longer eligible, especially by:

  --rewriting the section of the Disability Manual pertaining to continuing investigations and removing the restrictive language which may discourage SSA staff from terminating benefits, and

  --providing training to District Office personnel on the intent and mechanics of the CDI process.

--Improving the District Office and State agency capability to do thorough, timely investigations and to terminate benefits when warranted. One such measure would be to provide work activity information on the Master Beneficiary Record so the District Office can access this information when a beneficiary reports that he/she returned to work.

--Measure the impact of annual wage reporting on detecting program overpayments, and if warranted, devise alternative methods to identify those beneficiaries who returned to work.

--Periodically review cases where overpayments were caused by the CDI process to identify and correct problems causing the overpayments.

Department Comment

--We agree that the Automated Continuing Investigation Diary (ACID) system should and can be utilized to provide very important operational and management controls over the CDI workloads and it is being redesigned to do so. While waiting for systems modifications, we are exploring ways to collect and utilize the information manually. We expect the manual reports to be available and in use in the next few months. We have also begun on a manual basis the process of directing follow-up alerts to the cognizant work station in response to GAO's observation that follow-up alerts on delayed medical reexaminations were not reaching the staff responsible for scheduling them. This procedure will be automated at a later date.

--We acknowledge that in the past the continuing disability process resulted in some lost diaries, 1/ and better procedures are needed to recapture diaries that have been lost. However, we do not believe the methodology recommended by GAO is the answer since: (1) the SSA "833" file does not contain concurrent DI/SSI cases, and (2) the medical reexamination diaries can be legitimately deleted through a process which does not employ the SSA "833" form. We believe the best method to identify lost cases may be to match the "831" tape with the MBR. We are now refining our procedures.

As part of the refinement, we now require that every case have an entry in the medical diary field on the system prior to payment.

--Revised disability program instructions to improve the CDI process will be implemented in the spring. Training on the CDI process is expected to accompany issuance of these revised instructions to insure uniform implementation of the changes. We will also prepare material that emphasizes the Administration's policies and position on the CDI process and disseminate it to the field. This material will explain the intent and philosophy of the process so that field personnel will have sufficient support in interviewing beneficiaries and processing the CDI cases.

--Since September 1977, a full range of CDI-related data has been available on the MBR and its related systems. A trial work indicator is readily accessible to field and reviewing offices via the existing MBR query facility. Further queries will even provide the actual number of months of work activity. In addition, in November 1980, a pilot procedure was instituted which provides for direct DDS teletype of title II cessations to central office which result in immediate termination action being completed prior to the receipt of the folder in central office. National expansion of this pilot will be completed in early 1981.

--In order to measure the impact of annual wage reporting and as a possible source of current earnings information, we used mass mailings in 1978 and 1979 to solicit earnings information directly from the disabled beneficiary. Once the 1978 and 1979 data is processed for enforcement purposes, we will compare the information from the mass mailers to the annual wage data to determine the value of the mass mailers and the impact annual wage reporting has had on the CDI process.

--Review of the CDI process is ongoing with special emphasis on the cause of overpayments. Within the last 6 months alone we have altered the alert processes to speed up the conduct of CDIs, conducted a study designed to process CDIs without folders (earlier processing) and initiated the use of teletypes to assure the timely termination of benefits. Each of these actions is/was aimed specifically at reducing or eliminating overpayments or the causes of overpayments. It should be recognized that "due process" requirements do produce a certain amount of delay in effectuating terminations.

1/ The establishment of a reexamination date is called a "diary."

APPENDIX II

GAO Recommendation

That the Secretary study the feasibility of storing certain disability cases--perhaps those with "profiles" that indicate potential for medical recovery or potential for work activity--in the District Offices and assigning full responsibility for these cases to claims representatives.

Department Comment

We agree that improvements are needed in our overall case management so that continuing disability investigations will be conducted efficiently and on a timely basis. However, decentralization of folder maintenance to district offices as recommended by GAO has significant inherent problems because the folder must be available for other purposes than CDIs, such as payment processing. We believe the modularization of central disability operations, including control of folders, is a very positive step in bringing about improvements in case management. We are looking at other ways as well, including (1) conducting CDIs on a folderless basis, and (2) storing the medical portion of high risk folders in a field location.

Technical Comments

GAO note: SSA provided several technical comments which have been incorporated into the report.

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